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## CLINICAL LECTURES.

### INFLAMMATION OF THE UTERINE APPENDAGES.

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WOMEN, PHILADELPHIA.

*Gentlemen:* The patient upon whom I shall operate to-day has well-marked inflammation of the uterine appendages, and there is every reason for us to expect on the left side to find pyosalpinx, which I believe is of gonorrhœal origin. Our patient has been married nine years, is twenty-eight years old, has had two miscarriages, but no children; the last miscarriage was eight years ago. She has always suffered from dysmenorrhœa, which has grown steadily worse since her marriage. Leucorrhœa has always been present, and on several occasions has been quite irritating in character. Eight years ago she began to have groin pains and to suffer on exertion. Dyspareunia also became marked. Six years ago she had a labial abscess, and she has since had three others. She has never been confined to bed until September last, when all her symptoms became aggravated. From September to Christmas she was in bed most of the time, and from Christmas until the present (January 30) constantly. For the last three weeks she has been under my care, having all the symptoms of acute pelvic peritonitis, with chills, fever and sweats, indicating the formation of pus. The symptoms of pus formation were present when I first saw her, but she improved in every way under the medical treatment instituted. Operation was advised after recovery from the immediate attack. This I believe to be the wisest course.

Pelvic peritonitis is almost always caused by salpingitis, and many recurrences are

necessary, as a rule, to cause a fatal termination. Hence, unless there is evidence of the continuous formation of pus, with septic symptoms, or of a tendency of the peritonitis to become general, operation should be postponed until the patient has recuperated her strength, when she will be the less liable to suffer from profound shock.

The principles governing the management of inflammation of the uterine appendages are pretty well settled, nor does there seem much prospect of change without the discovery of new facts in therapeutics. When the inflammatory process has advanced to the formation of pus, either as pyosalpinx, abscess of the ovary, or suppurative peritonitis, operation and removal of the diseased appendages is demanded to save life. Spontaneous recovery is scarcely possible, save by the discharge of the pus through the skin, vagina, bowel or bladder—alternatives to exsection which are not to be entertained. The time for operation must be determined by the conditions present in each case.

The management of the appendages on the opposite side, when the inflammatory disease is unilateral, is still under discussion. Where the disease is of gonorrhœal origin, experience has shown that it is best to remove both appendages; because a gonorrhœal endometritis is left, which later infects the healthy tube and entails a second abdominal section for its removal. When gonorrhœa can be excluded with reasonable certainty, especially in young women without children, I would not remove the healthy tube and ovary, unless there be some particular reason for it.

Our patient has had the usual preparations for an abdominal section. For some days she has been on soft diet, has had daily baths, and has had the bowels well moved. This morning she had only a cup of coffee. The abdomen has been washed with soap and water, with water, with alcohol, and with

bichloride solution. She has also had a bichloride douche. The woodwork of her room has been thoroughly cleaned and washed with bichloride solution, 1-1000; and the room itself has been thoroughly aired. All the apparatus used about the operation has been similarly treated. This secures asepsis in our appliances. The instruments are heated to 290° F. for two hours. They are then put in trays and covered with boiling water. The gauze and sponges have been made aseptic after the formula used in this hospital. Before use they are freed from chemical antiseptics by washing in boiled distilled water. All the water used about the operation has been recently boiled, and has been either distilled or filtered before boiling.

The hands and arms of the operator and of the assistants have been thoroughly cleaned with soap and water and with a nail brush, then soaked in a saturated solution of permanganate of potash; and this has been removed by soaking in a saturated solution of oxalic acid. Finally they are washed in bichloride solution 1-1000.

The patient being now on the table we will again wash the abdomen with soap and water, and shave the region of the incision and the pubes. This adds greatly to the cleanliness of the field of operation and prevents detritus from becoming adherent to the pubic hair. The soapy water is now rinsed off, the field of operation is douched with bichloride solution and this again is washed off with boiled water. This gives us an aseptic field and aseptic appliances, with an entire absence of chemical solutions. From this time nothing but boiled water will be used for washing or douching, so that our patient will derive every benefit from antiseptic surgery and be in no danger of poisoning from chemical germicides.

As presumably the operation will be more than usually difficult the incision will be made relatively long—two and a half inches. The method used is to cut quickly down to the sheath of the recti muscles, which is likewise incised. (The slight hemorrhage can be disregarded as a rule. It usually ceases spontaneously, and besides it is better to dispense with pressure forceps as much as possible, as bruising the tissues does not favor primary union.) If the middle line is not apparent it is found by picking up the sheath of the rectus lightly and perhaps dissecting it to one side or the other. The posterior layer of fascia is now divided

and the præ-peritoneal layer of fat exposed. Up to this time the tissues have been divided in situ. As we approach the peritoneum it is best to pinch up the layer of fat and elevate it before cutting. In this way there is no necessity for the use of the grooved director. The peritoneum is incised in the same way. Before opening the peritoneal cavity bleeding from the incision should be controlled.

On passing my fingers into the pelvis I find a large inflammatory mass on the left side and a dilated and adherent tube on the right side. The tube is freed by pressing the adhesions off with the pulp of the index finger, until it can be drawn up, when the remaining adhesions are rapidly stripped off and the tube and ovary are well delivered, to be tied off in the usual way. On the left side the mass is made up of tube, ovary, broad ligament and bowel. Separating adhesions along the broad ligament an intra-peritoneal abscess is opened, containing about a half pint of pus. The tube can be plainly made out and freed, but it is not possible to find the ovary, which is imbedded in plastic exudate. As the abscess has been discharged, rather than prolong the operation with our patient somewhat shocked, I will tie off the tube and leave the ovary.

Next the peritoneum must be cleansed of this foul pus. For this purpose I will pour into the belly several pitchers of warm water and irrigate the pus sac by means of a Davidson syringe. The gravity flushing apparatus also affords a desirable method of douching the peritoneal cavity—perhaps the best. By removing the pus in this way there is little danger of sepsis or peritonitis. I have seen the foulest pus poured over the bowels by the pint, and yet when it was thoroughly washed away no trouble resulted. In this way but little sponging is required.

A short drainage-tube of medium size is now inserted. The tube should not reach the floor of Douglas's pouch, as injurious pressure might be made by it, and unnecessary pain would certainly be caused. The drainage-tube is the sheet-anchor of success in pus cases, and in all cases with many adhesions.

Deep and superficial stitches are now placed in position by means of the needle and carrier, and the sponges are counted to be sure that none is left in the abdomen. A nicer approximation of the sutures can be made by tying the superficiales first.

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tube; powdered iodoform and boric acid (1-7) is sprinkled along the incision; gauze is laid over the region of the incision; a liberal layer of bichloride cotton is put in; and the Scultetus bandage is applied. Dressed in this way the tube is protected from atmospheric infection by the bandage and the cotton, and need be cleaned but twice daily, as a rule, because any excess of fluid is taken up by the gauze strip and cotton by capillary action.

The patient will now be put in bed and surrounded with warm-water cans, to recover from the shock and the ether.

[NOTE.—She made an uninterrupted recovery.]

# SCURVY.—TYPHOID FEVER COMPLICATED WITH RHEUMATISM.<sup>1</sup>

BY JAMES B. WALKER, M. D.,

VISITING PHYSICIAN TO THE PHILADELPHIA HOSPITAL, ETC.

*Gentlemen:* The first patient I bring before you came into the house four days ago, and you see him to-day about as he came in. He is pale, anemic and sallow; his lips are pale, his ocular conjunctivæ yellowish and blue; the palpebral conjunctivæ are also pale. His gums are swollen along the borders of the teeth, and present a red line with some points of ulceration along their free edges with slight bleeding at one point. The odor from his mouth is offensive, and examining the interior of his mouth purplish fungous masses may be seen within the upper molars on both sides almost on a level with the crown of the teeth. On exposing his legs we find them covered with little spots, with here and there larger areas of discoloration, like bruises. The spots are small petechiæ, and resemble the petechiæ occurring in typhus fever, in that they are minute points. They are situated around the hair follicles, and are extravasations of blood in which there has been an absorption of the liquid portion of the exuded blood, the coloring matter remaining. Besides these spots, there is a swelling along the lines of the tibia. On the left side this consists of a node-like prominence evidently subperiosteal. On the right side the entire calf is hard and rigid, the leg feeling like a piece of wood wrapped in cloth, or like a cork

leg. The surface of the limb is smooth. The entire limb is swollen; but the foot is not swollen, showing that this is due to some local effusion. The skin covering these swellings is yellowish and resembles that of an old bruise. Taken in connection with the other symptoms this case is very typical of a diseased condition. The prominences are due upon the one side to an effusion under the periosteum, and on the other side—where it is more extensive—to effusion into the intermuscular tissues.

Scurvy is a disease not often seen at the present time, owing to the use of canned vegetables and fruit juices, especially of the lemon and lime, in long cruises at sea. This man has been a worker in a brick-yard in Manayunk and is not a seaman. Previously he has always been healthy. His diet, while at work, consisted of bread, milk, coffee and soup, but no vegetables. He has had no headache, nausea nor vomiting. He denies specific history, and has not been addicted to the use of alcoholic liquors. He has simply been confined to a limited dietary and one without much variation for a long period. The absence of vegetables, especially of potatoes, from the diet is usually associated with scurvy. During the potato famine in Ireland the many who died, died of scurvy.

What, now, are the characteristics of this trouble? Upon examining the blood we find that it is deficient in coloring matter. My colleague, Dr. F. P. Henry, in an account of two cases which he reported last year, found that in one the number of red corpuscles had been reduced to 55 per cent. of their proper number, and in value in hæmoglobin to 30 per cent., thus greatly reducing the value of the blood in its oxidizing property. In the other case also it had been reduced to 39 per cent. There is, thus, in these cases a deficiency both in the number of the red corpuscles as in the quantity of hæmoglobin. There is no excess of the white blood corpuscles, but on the contrary these are also reduced in quantity. It is not, therefore, a case of leuco-cythemia, but a disease in which both of the corpuscular elements are very materially reduced. This occasions the marked anemia of scurvy. Sallowness of the skin is often associated with this anemia, as in this case, and in some cases other evidences of jaundice. The other features in the blood are an increase in the amount of fibrin and fibrin-forming material.

<sup>1</sup> Delivered at the Philadelphia Hospital.



The hemorrhagic tendency is a prominent characteristic of scurvy. Simple purpura presents the same characteristic, that is, a number of petechial spots; but as a rule they are larger and more maculated. In purpura there is no involvement of the gums, and, as a rule, no hemorrhagic tendency, though at times this is present. If we have a case in which there are petechial spots on the limbs, with no tenderness of the gums, we can hardly call it a case of scurvy. If a tooth is lost, the gum covering its site does not become fungous. It is only around the teeth that the fungosities are found. Upon pressing upon the borders of these gums I can express a purulent fluid from the little abscess cavities.

In the case before us I have had a study of the blood made by my friend, Dr. Judson Daland, who reports that the blood seems more diffuent than normal, issuing from the point pricked and spreading over the surface instead of gathering in a drop, as in normal blood. The blood corpuscles show decided changes in shape, presenting microcytes, megalocytes and poikilocytes: that is, red cells smaller than normal, others larger than normal, and others distorted and broken up, in decided and appreciable, though not excessive, degree. The blood count shows 1,900,000 red-blood cells per cubic millimeter—just 38 per cent. of what is normal (5,000,000 per cubic millimeter). The red-blood cells are not deficient in hemoglobin. This case presents, as you see, the characteristics of pernicious anemia, in the marked diminution in number and in the modification of the form of the red-blood cells. But as its cause is known and removable, the prognosis is favorable, despite the havoc already wrought.

Where may these hemorrhages exist? They may come from any mucous surface, from the gums, nose, stomach, kidneys, bladder or bowels. They may even take place from serous surfaces. Thus, we may have a hemorrhagic pleurisy. Some, among whom is Dr. Henry, query whether all cases of hemorrhagic pleurisies are not due to scurvy. In scurvy the digestion is poor, and constipation usually exists, except in those cases in which ulcerations exist in the large bowel, which are long in healing, and resemble in many respects the deep ulceration of dysentery.

The diagnosis of such a case rests entirely on the conjunction of a petechial eruption on the lower extremities with a swollen fun-

gous condition of the gums. Of course, all such cases are associated with anemia. There is no other disease for which it could be mistaken. It has nothing in common with the eruptive diseases. There is usually no fever in scurvy. The prognosis is always favorable except in extreme cases in which large serous hemorrhages have occurred. Here the strength may be so reduced as to result in death. But even in these cases treatment is often promptly effective.

The treatment is largely dietary. The point is to build up the blood. Substances to supply its need must be administered. Potatoes represent a prominent feature in many cases, together with vegetable acids. The mineral acids are also of use. We should exclude salt meats from the diet and place the patient on fresh, succulent foods, varying the diet as much as possible. Lime-juice is a valuable addition. Some form of iron is indicated. Bland's pills are vaunted in this disease as being preferable to the other forms of iron, but the tincture of the chloride is as serviceable in many cases, and I often prefer it because it is perhaps more readily absorbed; besides it is slightly astringent and slightly acid. Still, Bland's pills are also readily assimilated. In cases in which there is a marked hemorrhagic tendency, with petechiæ upon the surface of the body, and hemorrhages from mucous and serous surfaces, aromatic sulphuric acid combined with some preparation of iron is of great value. At times abscesses form in the exudations which take place into the limbs, but this is rare. Usually under treatment these swellings rapidly disappear. In many cases an anemic murmur is heard over the base of the heart, especially after exertion, and attacks of syncope are common in this disease.<sup>1</sup>

### Typhoid Fever with Rheumatism.

The next patient is a driver of an express wagon. His father is living and 85 years old; his mother is dead; his brothers and

<sup>1</sup> NOTE.—Two weeks later. An examination was made this day, at my request, by Dr. Daland, who reports that an average of 128 squares counted gave 3,435,000 red corpuscles per cubic millimeter,—a very notable increase over the count of two weeks ago. The red corpuscles were of good color and showed only an occasional megalocyte; and, though many microcytes were present, there were much less numerous than at the previous examination. The contour of the corpuscles was better preserved, and there were very few misshapen cells. The coagulability of the blood was increased.

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gisters are healthy. He has had no rheumatic history, and has never been sick. He has always been a hard worker. He was admitted on April 11 with pain in his side, which he said was due to a strain in carrying a heavy express package. Two days before his admission he felt sore and weak. On admission no injury could be found, nor were his joints swollen, but he seemed weak and dull. On the second day he was slightly delirious, with tenderness over the entire abdomen. On the evening of the second day he had an epistaxis. His pulse was distinctly dicrotic. His tongue, in appearance, approached that of typhoid fever. On the morning of the third day he complained much of pain in his legs and arms, but there was still no swelling. By the evening there was marked swelling of both knees and the right wrist, and a soft systolic bruit could be heard over the mitral area. Epistaxis also occurred this day and he still had pain in his abdomen. His left arm and shoulder-joints now became successively involved. There was no eruption; he was constipated; and there has been marked sweating throughout.

Here is an interesting case. He entered with pain attributed to muscular effort. His temperature on admission was  $104\frac{1}{4}^{\circ}$ ; in the evening at eight o'clock it was  $103\frac{3}{4}^{\circ}$ . On the following day he was delirious. His abdomen was as tender in the left iliac region as in the right, and from time to time he had a voluntary stool. His temperature was lower in the morning and high in the evening, but until the morning of the fifteenth day was constantly above  $100^{\circ}$ ; never reaching the normal for nineteen days except in the periods between the regular times of taking. It is not a rare thing in typhoid for the temperature to vary in the intervals two or three degrees, and typhoid fever charts, where the temperature is recorded every two hours, will often show a constantly varying fever. To look at this chart, I should say, with the history we have given, that one is justified in concluding that typhoid fever has been existent here, in spite of the other symptoms recorded. Rheumatism is a disease of slight fever. While acute rheumatism is synonymous with rheumatic fever, still the fever is not high, and the rise is usually proportionate to the number of joints involved. This man was admitted with no joint involvement, but with a higher temperature than at any subsequent time. This shows very clearly that

something else existed in his system inducing fever. He has been accustomed to muscular exertion, and this is associated with perspiration. He was, therefore, by his occupation, in just the condition, to take a chill and get an attack of rheumatism. But before there was any involvement of any joint, before the rheumatic poison had stirred up any inflammation at any point, he had a higher fever than at any subsequent period. We may say, then, that he had a febricula due to the development or retention of certain poisons in his system, or else that he had typhoid fever. The Germans call "typhoid" all cases of fever which cannot be otherwise explained, and this method of diagnosing a typical typhoid fever, by exclusion, is the only safe one. Any fever, continuing as this has done, which has no other appreciable cause, may be safely classed as typhoid in our climate.

This patient, then, has had typhoid fever complicated with rheumatism. With the new involvement of his joints there was no marked temperature exacerbation except once. His pulse has varied from 90 on admission to 120 on the second day; but has been running most of the time below 100. This is also suggestive of typhoid fever. It is remarkable how slowly the pulse weakens in typhoid fever. The two points in connection with this man's pulse which assist us in our diagnosis are its dicrotism from early loss of vaso-motor tone due to the presence of the typhoid poison, and its comparative slowness. Rarely does the pulse in typhoid fever reach above 108, though there be other marked signs of depression. This is strongly in contrast to the other fevers, where it rapidly rises to 140-160 or even 200 in a child. The presence of constipation is not of any value to us. Very often it is present in typhoid fever. His tongue is coated with a yellowish fur, but the lips and edges are clean and pale. Projecting above the fur can be seen the fungiform papillæ. This is not the typical typhoid tongue, but we must remember that the man's temperature is now almost normal, and has been so for several days.

The treatment of the rheumatic element occurring in typhoid fever should be largely local. The joints should be wrapped in flannel which may be saturated with a solution of nitre, to reduce the local heat. Salicylic acid or preferably salol, which is not so depressing and is better borne by the stomach, may be administered internally.

## COMMUNICATIONS.

HYSTERECTOMY FOR LARGE SUB-PERITONEAL FIBROID.<sup>1</sup>

BY W. E. WILSON, M. D.,

PULASKI, TENN.

On April 25, 1889, I was called upon by my friend, Dr. G. D. Gray, of Giles County, to perform an operation upon a patient of his, Eliza W., colored, 55 years old, for an abdominal tumor, the exact nature of which had not been clearly determined. Accompanied by several of my medical friends, we drove into the country to meet Dr. Gray, and to render him and his patient all the help we could. We found our patient in a nice, clean room, but very dark and ill-suited for the work before us. She was in fine spirits and fairly good condition, though greatly reduced in flesh and strength. On examination, a large, smooth, symmetrical tumor was found, about the size of a seven months' gravid uterus. Upon consultation it was agreed that an operation was necessary, the character of which could only be definitely determined after the exploratory incision was made. We were poorly equipped for such an operation, and each physician present contributing something to the armamentarium, and rendered invaluable assistance by suggestions and manual help. We proceeded at once to operate.

We were compelled to place the table before an open door, it being the only light available in the house. Our little woman, who weighed less than one hundred pounds, mounted the table with such marked fortitude, that we were inspired with hope of success. After shaving the pubic region, and thoroughly cleansing and disinfecting the abdomen, the ordinary incision was made, which rendered the diagnosis clear, and demonstrated the absolute necessity of hysterectomy, a large fibroma being found growing in the posterior uterine wall. The incision was extended down to the pubes, and to about two inches above the umbilicus, and through it the tumor was drawn with considerable difficulty. The adhesions between the tumor and the parietal walls and abdominal viscera were extensive and firm, requiring considerable force to break them down. Some points bled quite freely,

though in no case was it deemed necessary to apply a ligature.

The right broad ligament was ligated and detached, but the left was so closely identified with the tumor that it could not be separated easily, and was taken into the clamp with the cervix. The clamp being placed as high as practicable, and being made tight, the body of the womb was severed by a few strokes of the scalpel, just above the internal os. The stump was then thoroughly seared by means of a Paquelin cautery, a double ligature was passed through it below the clamp and each segment was securely ligated. The clamp was then removed and the cavity was carefully cleansed of blood by means of sponges wrung out of hot carbolized water. We did not use irrigation, and avoided the introduction of even the carbolized water into the abdominal cavity as far as possible. The stump was then stitched into the lower angle of the wound with two deep silver sutures, by the side of which an ordinary perforated drainage-tube was passed well down into Douglas's *cul-de-sac*; the remainder of the wound was closed with wire and silk sutures. The parts were then thoroughly dried, and the wound dressed with dry carbolized gauze and cotton, and a bandage was applied. We put our patient to bed with many misgivings in our minds in regard to the result.

After the nausea and prostration incident to the chloroform and shock of the operation had passed off, there was not an unfavorable symptom. The temperature was never higher than  $99\frac{1}{2}^{\circ}$  F., except on the second day, when it reached  $101^{\circ}$ , and the pulse after the second day was never as high as one hundred per minute. The wound above the drainage-tube healed perfectly by first intention, there being no appearance whatever of pus. There was little or no discharge from the tube until the sixth day, when a puro-sanguinolent discharge made its appearance, containing numerous small partially decomposed clots of blood. This soon assumed a healthier aspect; by the eighth day it was like ordinary laudable pus, and it gradually diminished in quantity. Day by day I withdrew the tube a little, until it was finally removed on the eleventh day. I did not wash out the cavity at any time, as there was never the slightest evidence of septic trouble.

During all these days the patient had very little tenderness and less pain, and expressed

<sup>1</sup> Read before the Tennessee State Medical Society, in Memphis, April, 1890.

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herself as feeling greatly relieved by the removal of the tumor. On the eighteenth day I removed the only two remaining sutures, which had been passed through the stump, when the ligatures came away, bringing with them, to my great gratification, the remnants of the stump. From this time my patient progressed rapidly to perfect recovery.

After she was well and able to do her housework, she disregarded my positive instructions, and left off the abdominal support; in consequence she has a small hernia. At this time, almost twelve months after the operation, she is strong and well with the exception of the hernia, and, according to her statement, is in better health, and can do more work, than at any time in fifteen years.

There is little to be gained from the report of this case, except encouragement to those who may be similarly forced by duty to perform so grave an operation when the surroundings are not everything they might wish. Poorly performed as this operation was, and unpromising as were the surroundings, it was undertaken purely from a sense of duty, and resulted in life and health to this poor sufferer.

# SURGICAL CASES OCCURRING IN THE PRACTICE OF A COUNTRY PHYSICIAN.<sup>1</sup>

BY T. J. HAPPEL, M. D.,  
TRENTON, TENN.

Feeling that it is profitable at times to review work done, and knowing that reliable statistics in surgery can be obtained only by reporting alike favorable and unfavorable results, I have ventured to call your attention to a consideration of most of the more important surgical cases that I have treated for the past several years. An investigation of such work ought to be, to some extent, profitable to the general practitioner, as he knows not when he may be forced, in some emergency, to take up the tourniquet and scalpel.

I would state at the outset that, whilst believing cleanliness is next to godliness, cleanliness is conducted in my hands on the general principles of antiseptic surgery, ignoring its minute details. My general method of

procedure is to cleanse the parts thoroughly, first with hot water, and then with carbolized water. My instruments are carefully freed from the vaseline with which they are kept constantly coated, and are then immersed in a bath of carbolized water (f3 iij to Oj.) I prefer the carbolized water to the bichloride, from the fact that it does not tarnish my instruments. My sponges, after being cleansed, are immersed in a vessel of hot bichloride solution, 1 to 2,000, which is used during the progress of the operation. No spray is used. When the operation is finished, unless forced to haste in dressing, I delay closing the wound as long as possible, so as to check all hemorrhage as completely as can be done. When ready to coaptate the edges, I use a Hagedorn needle, and usually, iron-dyed silk, and then apply over the closed edges sublimated cotton, wetted thoroughly in a 1 to 2,000 bichloride solution; over that I apply a layer of dry cotton of the same kind, and hold it in place with bandages or adhesive plasters, as the case may demand. This dressing I disturb as little as possible, never changing it till suppuration points to the necessity for so doing. When a new dressing is needed, the wound is thoroughly cleansed again, and dressed in the same way as at first. This is the extent to which I use antiseptic precautions, or practice antiseptic surgery. I cannot boast of much of the poetical surgery of the present day, when "not a drop of pus is formed, and no departure from normal temperature takes place," for in most of my cases pus does form, and there is some elevation of temperature.

The nearest approach to what I might term "ideal surgery" that it has been my lot to deal with, was one of my latest operations—the removal of what appeared to be a cancerous degeneration of a nœvus or mole in an old woman, nearly ninety-three years old. This tumor, which had attained to the size of a duck's egg, was growing on the left temple and had developed rapidly within less than six months. It was removed under chloroform on April 21, 1889, and the patient was dismissed cured on May 5. There was no elevation of temperature, and less than a quarter of a teaspoonful of pus—but pus there was.

If it were not for the high standing and the known veracity of many of the operators, who state the non-existence of pus, etc., I should be much inclined to doubt the truth of many of the statements made

<sup>1</sup> Read before the Tennessee State Medical Society, April, 1890.



in reference to surgical operations in which the full history is not honestly and fairly reported. There are points that frequently remind one of Rip Van Winkle's swearing off from drinking. The small secretion of pus and the slight elevations of temperature "are not counted." We are not exactly willing to lessen the otherwise brilliant result of some capital operation by reporting the presence of pus and an elevation of temperature. I am not an unbeliever in all such reports, but I am fully convinced that many are exaggerated, and in many cases fatal results and terminations never reach the glare of the noon-day's sun. The successful cases are all reported, but the fatal ones are forgotten. The accurate history of antiseptic surgical operations could only be obtained by a report from surgeons, honestly and candidly giving all their cases for a given length of time—stating their mode of operating, and the after-treatment, and the result in every case, let that result be a success or failure.

In the first year of the existence of the Gibson County Medical Society, in an article entitled "Antiseptic Surgery," I reported all of my more important surgical cases up to that date, June, 1884. In that report I noted as follows: One lithotomy; one amputation of the thigh in its lower third; one Symes' amputation; two amputations in lower third of leg; one amputation of leg in upper third; two amputations of the arm, one just above the elbow, the other within two inches of the shoulder-joint; several amputations of fingers and toes; one amputation of the breast for cancer; three operations for lacerated perineum; one for bilateral laceration of the cervix uteri; one excision of the lower half of the ulna for an exostosis, and one resection of six inches of the middle of the radius for a comminuted gunshot wound; two cases of hare-lip; twelve cases of fistula in ano; one fibroid polypus; one mucous polypus; several fatty tumors, one from an old lady sixty-eight years old; one case of friction-burn in a man sixty years old, and numerous cases of circumcision. In every one of these cases the result was everything that could be desired, so far as recovery was concerned. In the case of amputation of the breast for cancer the operation was a success, but the disease recurred internally and the patient died within six months. (See MEDICAL AND SURGICAL REPORTER, April 11, 1885, page 449.)

Looking at my case-book since that time, I find a number of important cases to which I would briefly invite your attention. In every case the importance of cleanliness is impressed upon patient and nurses. In the first half of the cases, the antiseptic agent used was carbolic acid, but the latter half have been, as a rule, treated as suggested in the first part of this paper. I am not prepared to decide on the relative merits of the corrosive sublimate solution as compared with carbolic acid. I must confess that I have seen but little difference in the results obtained in the use of the two agents. Fashion now says the bichloride is the antiseptic agent, *par excellence*. For patients who have illiterate and careless nurses, I prefer to use carbolic acid, as its odor proclaims its presence, and it is easy for them to understand and act upon the directions to add one teaspoonful to the pint of water for dressing purposes. For abdominal surgery, to the bichloride is awarded the first place; but it is not my intention to discuss the relative merits of any of the agents now in use. Suffice it to say that their name is legion, and their modes of being used varied.

Among the cases operated upon, I would invite your attention to the following: Dec. 4, 1884, H. P., colored male, about sixty years old; a case of moist gangrene of the leg, due to embolism. When seen the line of demarcation had been established and there was no question as to what should be done. The leg was removed in the upper third. The patient's reaction was slight, and there was a very slight disposition on the part of the anterior flap to slough. The administration of tonics, cleanliness and careful feeding steadily improved the patient, and in less than two months he was discharged cured, and is now well and strong.

June 6, 1887, J. J., twenty-one years old, white male; his hand and half of his forearm had been torn off by a wheat thresher; the remaining part of forearm so much lacerated by the spikes of the thresher as to leave no tissue suited to cover the stump. The arm removed just above the elbow by flap operation. The condition of the patient was as good as could be desired. More than half the wound united by adhesion. The dressings were changed on the fourth day; on seventh day the stitches were removed. It was found that a fly had deposited its eggs on the wound at night, while nurses dozed; and about a dozen maggots were removed. The dressing was renewed and in another

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week I dismissed the patient. The temperature did not go over  $100^{\circ}$  F., and pulse not over 90 per minute.

On September 7, 1888, I amputated a negro's arm for gunshot wound received four days previously. The patient, when first seen, was found to have a comminuted fracture of the humerus and great laceration of the muscular tissue, the result of a load of squirrel shot. The wound had not been dressed from the date of its reception until the time of my visit. A most foul, offensive odor pervaded the negro's hovel, and when the clothes were removed, maggots were seen crawling in every direction. The arm was removed just one inch below the shoulder-joint. The shock was profound. *Belladonna*, *digitalis* and *nuxvomica* were used hypodermically. The wound was thoroughly cleansed with carbolized water and dressed with carbolized cloths. Cleanliness was enjoined, and abundant feeding. In two weeks the patient was walking around.

Jan. 2, 1889, M., white male, about 40 years old, had had his hand cut to pieces in a gin and his arm almost torn off. I amputated at the lower third of forearm. The patient's recovery was slow; the wound had a decided tendency to slough, and numerous small spiculæ of bone were discharged. The arm even now pains and annoys the patient. In this case antiseptic precautions were more carefully resorted to than in any of the preceding cases, and yet suppuration was profuse, the odor of the discharge offensive, and recovery, as has been already stated, slow.

In December, 1884, I amputated a thumb which had been almost torn off by a rope, the adjacent tissues being burnt by friction. In June, 1885, I amputated the second and third fingers of a cotton factory employé. The fingers had been mangled by cog-wheels. In both cases there was much suppuration, but finally good recoveries were made.

In July, 1885, I amputated the little toe of both feet in one patient at one time. Here union took place with scarcely a drop of pus forming, but the wounds being injured by the patient's walking too soon, slight inflammation set up later on, with some suppuration; however, a rapid recovery resulted. In September, 1885, I removed an epithelioma of the lower lip in a young man 23 years old, removing a V-shaped piece of the lip  $1\frac{1}{2}$  inches along the lip and 1 inch deep. Union by first intention resulted,

with no return of the disease up to the present time. On June 25, 1888, I performed the same operation on a man about sixty years old, with the same results. The closest inspection is required in both cases to decide the part of the lip operated on.

On June 26, 1888, I removed an encephaloid cancer from the back of a man 40 years old. One month later the axillary glands were removed from the same patient, and about six weeks later a second growth in the cicatrix where the first had been removed; at the same time an effort was made to remove one growing apparently at the base of the ensiform cartilage, but when cut down upon, it was found to grow from some of the internal organs, and simply to protrude at that point. At this point the wound was closed, and the patient sent home with the assurance that he needed no further operations. His right lung rapidly broke down, and he died within two months from the date of the last operation. The external wounds all healed rapidly.

On March 27, 1887, I amputated a breast for a scirrhus in a woman fifty years old. The father of the patient had died of epithelioma of the lip. The wound healed rapidly, but at the expiration of nine months the axillary glands began to enlarge. These were removed the following April. This wound healed kindly, but in the following September the disease returned in the axillary cicatrix and the patient rapidly succumbed, having lived about eighteen months after the first operation. In the two last-named cases no hopes of final recovery were held out to either patient. They were simply offered relief, which they obtained up to a short while before death.

On October 2, 1887, I treated a case of epulis in a woman about thirty years old. The growth removed was as large as a walnut, and occupied the space which had been filled by two inferior molars. The patient recovered without an unfavorable symptom. On October 21, 1887, a lacerated perineum was operated on; the woman being a primipara, twenty-five years old and very fleshy. The operation was performed at the end of the third week and was successful. October 18, 1888, I saw, in consultation with Dr. J. C. Moore, a case of traumatic synovitis of the knee-joint. The patient was of a scrofulous diathesis, and, when first seen, was almost in a hopeless condition. Free drainage was made, and the

joint washed out thoroughly with a bichloride solution, 1 to 2,000, with some apparent benefit; but in spite of the most careful antiseptic treatment of the joint, the patient died from septicemia. Tonics were administered; extension and counter extension was made and the nutrition closely watched, but all to no avail.

On April 9, 1887, I treated a case of necrosis of the middle third of the tibia in a boy 8 years old. In the upper and lower thirds the cancellous structure was in a carious condition. The entire diseased portion was removed, leaving nothing of the bone except the upper and lower epiphyses, and the shell of the dense structure in the upper and lower thirds. Carbolyzed washings and dressings were used and the patient rapidly recovered, being confined to his bed a few days only. In two cases of caries of the tibia, one operated February 23, 1885, and the other July 18, 1887, nearly all of the cancellous structure was removed in both cases. The dressings were the same as in the preceding case, and the patients were kept saturated with tonics of iron, arsenic and cod-liver oil. All of the patients recovered.

On May 27, 1885, a case of scrofulous osteitis, followed by necrosis of a small portion of the inner surface of the lower extremity of the femur, in a boy four years old, came under observation. The diseased portion was exposed and the shell of bone was removed; thorough drainage was established and kept up; carbolic washes were freely used; the patient was kept on tonics and alcohol in divers forms, and finally made a most excellent recovery and is now a robust boy. Sept. 13, 1887, a compound comminuted fracture of the fibula and tibia was treated with rest and antiseptic cleanliness, carbolic acid being used as the agent. There was at no time any elevation of temperature nor increase in the pulse rate. The man has now as good a limb as the unbroken one, with almost no deformity. In Nov., 1883, I successfully treated a compound, comminuted fracture of the tibia, caused by the kick of a horse. I find in my records two cases of simple fracture of the thigh, two of the tibia, six of the arm and forearm. One fibro-cystic tumor growing from the cervix uteri, which had originally filled the whole vaginal canal, was removed Dec. 6, 1887. Three cystic tumors of the scalp were removed from one old lady, at one sitting, without chloroform. Several other cystic

growths have been removed during the time covered by this paper, and in no case has there been any return. Three fatty tumors of medium size were removed. Two cases of hydrocele have been treated, both by tapping, drawing off the liquid, and then injecting with equal parts of iodine and glycerine, to which about 20 per cent. of carbolic acid had been added. Both cases recovered and in neither has there been any return. Two cases of fistula in ano were treated with the knife, the fistulous tract being laid open into the rectum. Both recovered in a short time. One patient is now under treatment, who is recovering very slowly. (This patient finally died.)

On Dec. 14, 1884, I was called to see and treat, in conjunction with Dr. Stephenson, of Dyer, a case of friction burn, in which the young man had been caught between the beam and inclined wheel of a cotton gin, and where the beam had held him down in a space not wider than two and a half or three inches, and had revolved over the lower dorsal and lumbar regions, causing a most extensive friction burn. The skin and much of the muscular tissue over an oblong space of six by ten inches sloughed out, exposing the muscular tissue, some of which also sloughed. Under carbolized dressings the patient rapidly recovered and is now well, without any deformity whatever.

On Dec. 12, 1887, I was called to treat a gunshot wound of the forearm, in which half of the muscular tissue on the anterior aspect had been torn off by the discharge, at short range, of a gun loaded with bird-shot. Fortunately the arteries and bone were uninjured. The torn shreds of skin and muscular fibre were chipped off and as much as possible of the powder burn and fragments of clothing was removed. The arm was thoroughly cleansed by washing it in hot carbolized water and then dressed with carbolized jute. Profuse suppuration ensued, but the patient rapidly recovered and now has a useful arm. I saw and watched one fatal gunshot wound, where one ball struck the patient posteriorly and glanced along the sixth rib, entering the spinal column through the forearm and imbedding itself longitudinally in the cord itself, producing complete paraplegia. Death ensued on the eighth day in this case.

I find four or five cases of operations for enlarged tonsils; five cases of circumcision. My book shows about two dozen cases of internal hemorrhoids, all treated by hypodermic

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I have operated on the growth of the breast from the seventeenth century, and I have referred to the fact that where a woman is probably upon the whole lower in a woman's life. In a word, the Theorem depends upon the aesthetic less than the pulse chloroform. One can see the aesthetic anaesthesia chloroform its use. No experiment the difference in the gradation in real



injections of carbolic acid, with recovery in every case. In not more than two of the cases was there any sloughing, the cure being generally accomplished by a mummifying process. I have never been compelled to treat a case a second time, and know of but one case in which after the lapse of five or more years there has been any re-development: a state of affairs in marked contrast with the operation by ligature, or clamp and cauterization. There are seventeen cases of rectal ulcerations in my list of operations. Of these, one was tubercular, preceded by ulceration of the whole alimentary canal. In this one case, while there was for a time marked improvement, later on the patient failed rapidly and died. I would remark that the prognosis was very unfavorable in this case when first seen, about six weeks before her death. The other cases all recovered promptly. Some of these cases were reported by me in a paper read April, 1888, at the State Medical Society, Knoxville, Tenn. For details of treatment reference is made to that paper.

I have now under observation one case operated upon for caries of the superior edge of the acetabulum, and one in which a small growth with a cancerous history was removed from the left temple of a woman nearly seventy-five years old. I desire to call your attention to this case and the similar one referred to in the first portion of this paper, where a similar operation was made for a like growth located in the same temple of a woman nearly ninety-three years old. This is probably the oldest person ever operated upon in the State of Tennessee, and was followed by a case almost a duplicate of itself in a woman of advanced years, namely, about seventy-five years old.

In all my operations I use chloroform. Theoretically, ether may be safer, but much depends upon the manner in which the anæsthetic is used. Both are unsafe in careless hands: chloroform being much more so than ether; but when the respiration and pulse are carefully watched, I consider chloroform as safe as ether. Of course, no one can operate and administer the anæsthetic at the same time. In my hands I find anæsthesia much more rapidly produced by chloroform, and much less nausea following its use. In mixing anæsthetics, I have had no experience and less faith; as, owing to the different rates of volatilization of the ingredients, the patient uses but one at a time in reality. With other agents than chloro-

form and ether I am not acquainted, and could only speak of them theoretically. In my opinion, one must choose ether or chloroform. Of course in minor surgery, for local anæsthesia cocaine is to be used in such strength as the occasion demands.

To sum up the results of my surgical work, my records show: Six amputations of the lower extremities; five amputations of upper extremities; seven amputations of fingers and toes; two resections; five operations for caries, or necrosis of the long bones; four cases of perineorophy; one case of tracheloraphy; two operations for epithelioma of the lower lip; two for hare-lip; one for stone in the bladder; one for epulis; a large number of cases of anal fistula; and many cases of rectal ulcers and internal hemorrhoids, with recovery in every case except one case of tubercular ulceration of the rectum. I have twice amputated a mammary gland for scirrhus, with recovery in both cases from the operation; but death in one case from recurrence in less than six months, and in the other within less than two years. A similar result obtained in the encephaloid cancer. The fatal case of synovitis of the knee-joint could not at the time I saw it have been expected to result otherwise.

The results of my surgical work are before you. I do not see where I could have expected them to be better, and yet, as I stated in the outset, I have seen but little of the poetry of surgery. I am a believer in antiseptic surgery so long as it forces upon us greater cleanliness, but I am not yet fully satisfied that the micro-organisms which are supposed to be destroyed by our antiseptic lotions, etc., are the causes of the disease. They may be simply sequences. The disease may furnish them suitable pabulum on which to grow, and they develop as a result of the disease. Perhaps, after all, the antiseptics only prevent the furnishing of this *tertium quid* on which the bacilli and micrococci grow and thrive.

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HYGIENE IN GERMANY.—During the past few years the subject of hygiene has received marked attention from the German Government. In nearly all the leading universities there are now hygienic institutes, thoroughly equipped in every way. Recently the new Hygienic Institute in the University of Halle was opened. The Institute has a lecture-room and also special chemical, physical and bacteriological laboratories.

## REMOVAL OF A TAPEWORM TWENTY-FOUR YEARS IN THE BOWEL.

BY SAMUEL LILE, M. D.,  
TRINITY, ALA.

I report this case, as it has points of considerable interest, as regards the diagnosis of tænia and the means adopted for its removal, hoping that it may be of benefit to other members of the profession.

George C., negro, 54 years old, of exceedingly good moral habits for one of his race, has lived in my section of the country for twenty years, and had enjoyed remarkably good health until August, 1889, when he had a slight pneumonia. Two months later he had an attack of acute gastro-enteritis, from which he made a fair recovery. He did not apply to me again for medical aid until April 24, 1890. I then found him very much frightened, having just vomited some small clots of blood. After examining him and seeing no cause for special alarm, I began to make my prescriptions to meet the trouble, when I was interrupted by the patient, who said: "Doctor, I have, for a long time, been passing a strange-looking worm from my bowels, pieces pass every day or two; and whenever I fail for any length of time to pass a piece I suffer from sick stomach and a feeling of weakness."

I then began to inquire after the nature of the worm; when it was first seen, etc.; and he said: "In 1866, I passed a piece of a flat worm, knuckled together like a rattlesnake's rattle, which measured two feet in length. This alarmed me considerably, so I went forthwith to see a doctor, who told me that there was no occasion for alarm, as it would never hurt me as long as my health was good. Short pieces or joints from one-half inch to one inch long continued to pass every few days until 1876, when I passed a piece eight feet long. Still I felt no alarm, recollecting what my former family physician had told me ten years before. After this, short joints would come out while I was at work and without my knowledge, until I would find them in my clothes. Just after you dismissed me last Fall, after that attack of bowel trouble, I got a piece three feet long; but still, relying on what my physician told me in the spring of 1866, I felt not the least disconcerted. But I have seen no sign of it now for two weeks, and I thought maybe that was the cause of my

present trouble, and I had better tell you about it."

I then ordered an active purge, gave something to control the nausea and directed that any and all pieces of said worm that might escape be saved and sent to my office. The next day the man sent me a half dozen separate joints of a fine specimen of a tapeworm. I began at once to devise some means to dislodge the monster, the like of which I had never attempted before.

Pumpkin seed being the simplest and most available remedy, I decided to try them. I directed the patient to make a strong tea from the seeds, and to use it instead of water. After having used it for four days, I made an emulsion as follows:

Take two ounces of pumpkin seed, put into a mortar and pound, hull and all, into as fine a powder as possible. To this add half a pint of water and let it stand all night. I then ordered the patient to eat no supper or breakfast, but to take the emulsion instead of the last-named meal. Two hours later I ordered him to take two ounces of molasses and two hours later I gave him one ounce of castor oil with one drop of croton oil added. In another hour a monstrous tapeworm, three-fourths of an inch wide at the broadest part and fourteen feet four inches long was in our possession, having been completely dislodged, head and all, and passed ribbon-like and unbroken, not a single joint misplaced.

This is a case of very long standing (24 years) and one in which a very simple remedy proved remarkably successful.

I hope that it will prove as interesting to some others as it has been to me.

## HOSPITAL NOTES.

### WOMAN'S HOSPITAL, PHILADELPHIA.

SERVICE OF DR. JOHN B. ROBERTS.

#### Rules to be Observed in Operations.

The value set upon strict adherence to the principles of antiseptic surgery is indicated by the following rules which regulate the conduct of operator, assistants and nurses.

After wounds or operations high temperature usually, and suppuration always, is due

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to blood-poisoning, which is caused by infection with vegetable parasites called bacteria. These parasites ordinarily gain access to the wound from the skin of the patient, the finger nails or hands of the operator, or of his assistants, the ligatures, sutures or dressings. Suppuration and high temperature should not occur after operation wounds, if no suppuration has existed previously. Bacteria exist almost everywhere as invisible particles in the dust; hence, everything that touches or comes into even momentary contact with the wound must be germ-free; technically called "sterile." A sterilized condition of the operator, the assistant, the wound, instruments, etc., is obtained by removing all bacteria by means of absolute surgical cleanliness (asepsis) and by the use of those chemical agents which destroy the bacteria not removed by cleanliness itself (antisepsis).

Surgical cleanliness differs from the housewife's idea of cleanliness in that its details seem frivolous because it aims at the removal of microscopic particles. Stains, such as housewives abhor, if germ-free, are not objected to in surgery.

The hands and arms and especially the finger nails of the surgeon, assistants and nurses should be well scrubbed with hot water and soap by means of a nailbrush immediately before the operation. The patient's body about the site of the proposed operation, should be similarly scrubbed with a brush and cleanly shaved. Subsequently the hands of the operator, assistants and nurses and the field of operation should be immersed in or thoroughly washed with corrosive sublimate solution (1-1000 or 1-2000). Finger-rings, bracelets, bangles and cuffs worn by the surgeon, assistants or nurses, must be removed before the cleansing is begun; and the clothing must be covered with a clean white apron large enough to extend from neck to ankles and provided with sleeves.

The instruments should be similarly scrubbed with hot water and soap, and all particles of blood and pus from any previous operation must be removed from the joints. After this they should be immersed for at least fifteen minutes in a solution of beta-naphthol (1-2500) which must be sufficiently deep to cover every portion of the instruments. After cleansing the instruments with soap and water, baking in a temperature a little above the boiling point is the best sterilizer. During the operation

the sterilized instruments should be kept in a beta-naphthol solution and returned to it when the operator is not using them.

Sponges should be kept in a beta-naphthol or a corrosive sublimate solution during the operation. After the blood from the wound has been sponged away they should be put in another basin containing an antiseptic solution, and cleansed anew before being used again. The antiseptic sutures and ligatures should be similarly soaked in beta-naphthol solution during the progress of the operation.

No one should touch the wound but the operator and his first assistant. No one should touch the sponges but the operator, his first assistant and the nurse having charge of them. No one should touch the already-prepared ligatures or instruments except the surgeon and his first or second assistant.

None but those assigned to the work are expected to handle instruments, sponges, dressing, etc., during the operation.

When any one taking part in the operation touches an object not sterilized, such as a table, tray or the ether-towel, he should not be allowed to touch the instruments, the dressings or the ligatures until his hands have been again sterilized. It is important that the hands of the surgeon, his assistants and nurses should not touch any part of his own or the patient's body; because infection may be carried to the wound. Rubbing the head or beard or wiping the nose requires immediate disinfection of the hands to be practiced.

The trailing end of ligatures and sutures should never be allowed to touch an assistant or surgeon's dress or to drag upon the operating table, because such contact may occasionally, though not always, pick up bacteria which may cause suppuration in the wound. Instruments which fall upon the floor should not be used again until thoroughly disinfected.

The clothing of the patient, in the vicinity of the part to be operated upon, and the blankets and sheets used there to keep him warm should be covered with dry sublimate towels, and all dressings should be kept safe from infection by being stored in glass jars or wrapped in dry sublimate towels.

**REMOVAL OF FRECKLES.**—Freckles are said to be readily removed by a lotion of equal parts of lactic acid and glycerine.



## FOREIGN CORRESPONDENCE.

## PARIS LETTER.

*On Scrotal Pneumocoeles.—Treatment of Endometritis by Curetting the Uterus.—The Galvanic and Faradic Electrical Treatment.—Its Use in Muscular Atrophy.*

At one of the last meetings of the Academy of Sciences, Prof. Verneuil made an interesting communication on scrotal pneumocoeles, of which the following is an extract. The presence of infiltrated or collected gases which sometimes occur in the scrotum produces either a diffuse or a circumscribed swelling. The pathognomonic symptom of such an affection is a sonorous percussion sound with or without gaseous crepitation. The author does not think that the denomination of emphysema of the tunica vaginalis is a sufficiently expressive term for it, and proposes to call it scrotal pneumocele.

Several varieties of this affection are to be met with, and differ according to the location in which the gases are situated; constituting either a sub-cutaneous pneumocele or a vaginal or serous pneumocele. They also differ according to the chemical composition of the gas. In the aeriform pneumocele the gas is exclusively atmospheric air. In the bacterial pneumocele the gases are made up of the elements of the atmospheric air plus the gases of putrefaction.

Scrotal pneumocoeles are also divided according to the way in which they react towards the general economy into, 1, the benign pneumocele, and, 2, the septic or malignant pneumocele. There are two principal forms, however,

1. The scrotal, aeriform, benign pneumocele, whatever its seat—sub-cutaneous or vaginal.

2. The malignant bacterial scrotal pneumocele; which occupies the connective tissue meshes, or the peritesticular serous membrane.

Scrotal pneumocoeles are never idiopathic; they are always preceded by a local lesion or due to a distant lesion. The local lesions are either wounds of the scrotum with introductions of atmospheric air; hydroceles or hematoceles, in which the appearance of the gas seems to be spontaneous; or punctures made with a trocar.

The distant lesions may be: Wounds of the air passages and adjoining cavities of the head and neck; wounds of the intestine in the abdomen or of the ano-rectal region or hernial region; wounds, whatever may be their seat, which are complicated by aerial or bacterial emphysema, the gases of which can become infiltrated into the scrotum; finally, all acute inflammations situated near the genital urinary apparatus of man.

In sub-cutaneous, aeriform or vaginal pneumocele, the accidents remain local and without complication; and hence the prognosis is a good one, and the treatment consists in making simple punctures. In the bacterial form, the phenomena observed are those of acute inflammation, grave inflammatory cedemas, even gaseous gangrene; and the prognosis is a very grave one. As to the treatment, it must be applied as early as possible and very vigorously. Very large incisions are required, even excisions of part of the scrotum, or castration in cases of pneumo-hematocele of long duration and complicated.

Dr. Bouilly presented before the *Société de Chirurgie* the result of his experience in treating endometritis by curetting the uterus. He presented a series of 81 cases—69 of them having been seen several months after the operation. Simple endometritis or endometritis complicated by slight inflammation of the uterine appendages has been treated in that manner. All cases in which there was an ectropion of the neck of the uterus or uterine fibromas, were left aside. The symptoms observed in the patients who were treated by curetting were: metrorrhagia and more or less abundant mucous or muco-purulent discharges and variable pains. All patients were anaesthetized with chloroform. The cervix is always previously dilated with iodoform luminaria digitata: a small one the first day, followed by a larger one the following; and on the third day the operation has always been possible. Sims's curette is the one used. It is pressed strongly against the uterine mucous membrane, so as to remove it entirely. Then an injection of creasoted glycerin, 1-3 in strength, is made in cases of mucous endometritis; while the chloride of zinc, 1-20 in strength, is used in cases of hemorrhagic endometritis. The parts are then to be kept scrupulously clean to prevent reinfection. Out of 69 cases which were subsequently seen, 39 were completely cured, 19 were

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cases of hemorrhagic endometritis, and 20 of mucous endometritis.

In 15 cases there was great improvement, and finally, in 15 other cases, no change at all.

Dr. Bertrand, of Toulon, gave a description before the last meeting of the *Académie de Médecine*, of a peri-hepatic friction sound encountered in abscess of the liver. He thinks it to be a very important diagnostic sign. This peri-hepatic friction sound can be noted by the ear as well as by the hand applied on the right hypochondrium, more often on a level with the seventh or eighth intercostal space, in the anterior axillary line, which indicates its peritoneal origin. It may be possible that this friction sound may be due to an inflammation of the pleura and not to that of the peritoneum; but this is of no great importance, as the peri-hepatic friction sound would then be due to a dry pleurisy having for origin the peri-hepatitis. The circumscribed inflammation of the peritoneum is in all cases the primary cause of the friction.

Not only does the peri-hepatic friction sound point to an abscess, but it is also a proof that the liver is fixed to the abdominal parieties by the peritoneum, which is of no less importance in a surgical point of view. The highest friction sound always corresponds to the most painful part; it is always at this point that the parietal oedema will appear.

Prof. F. Raymond, of the Paris Faculty of Medicine, employs the Galvanic and Faradic electrical treatment in the following manner, especially in the treatment of muscular atrophy. Muscles can be treated by either the Galvanic or Faradic electricity. If the Faradic current is employed while the muscle is in communication with the conductors, this particular muscle undergoes a series of rapid contractions; while, on the contrary, if the Galvanic current is applied, only two contractions are obtained, one when the current is opened, the other when it is closed.

Hence for the stimulation of the contractility of muscular fibres, the Faradic current is the one to be recommended; and the mode of applying this Faradic current according to what we desire to obtain, either local Faradization or a generalized one. The localized Faradization has for its object to act on an individual muscle; it is either direct or indirect.

Direct Faradization is to influence the

muscular substance directly. For this purpose the two moist electrodes are placed on the external integument corresponding to the muscle to be electrified; the dry electrodes are only to be used when the superficial integuments are to be influenced.

Indirect Faradization is used to obtain a contraction of the muscle through the intermediary of the motor nerves which supply it. One electrode is to be applied at any indifferent part, while the other, the active electrode, is to be placed in a region where the nerve trunk which is to be influenced passes superficially. Each local Faradization must be continued for ten minutes at one seating.

Generalized Faradization, on the other hand, has for its object, to act on all the peripheral nerves. The patient is placed on a chair, with his bare feet resting on a stool presenting the form of an inclined plane. This inclined plane is covered with a plate of iron or copper, which is separated from the patient's feet by a piece of moist flannel. This plate is in communication with the fixed pole of an induction electrical apparatus; the other pole terminates in a wire brush, or a wet sponge, which is to be applied to the different regions of the body, beginning at the back of the neck, applying the brush especially on the painful spots and regions corresponding to the first, second and seventh cervical vertebrae. It is then carried successively to each side of the back, on the chest, abdomen, and especially in the epigastric region (on account of the solar plexus), the upper and lower extremities, and finally, the head is Faradized, using here the hand as an electrode. Each sitting ought to last about fifteen minutes, and be divided as follows: one minute for the head, four for the neck and cervical region; three for the back; three for the abdomen; and four for the extremities.

In the treatment of muscular atrophy due to a spinal lesion, anterior polyomyelitis, or progressive amyotrophy, we must act at the same time upon the central lesion and the peripheral alteration of muscles. To restore the contractility of muscular fibres Faradization of the involved muscles must be recommended; while on the contrary, to combat the spinal lesion and to act favorably on the nutrition of the anatomical elements and tissues, we must resort to Galvanization of the vertebral column.

The Galvanization is to be done by applying the positive pole at the back of the neck,

and the negative one in the lumbar region. This is kept up for two minutes; when the poles are reversed, positive in the lumbar region and negative in the back of the neck. Two or three sittings a week are to be recommended. In acute anterior polyomyelitis, or in lesions of recent occurrence, Galvanization must be kept up for from two to four minutes. In spinal lesions, of slow progression, the electrical treatment is to be kept up longer. In recent cases the treatment must last from six months to one year; in old cases two treatments of three months' duration are called for yearly.

As regards more general news, a new law regulating the practice of medicine in France has just been presented to the French House of Representatives. Amongst its special clauses is one forbidding the practice of medicine in France, to any one who is not a graduate of one of the French schools. I am sorry to say that this has been brought about by the way in which certain foreign medical schools have conducted the teaching of medicine; creating graduates by the cartload, and in a lapse of time which is hardly sufficient to prepare a man and render him capable of even understanding the medical lectures delivered to him.

### PERISCOPE.

#### Contagiousness of Leprosy.

In the *Lancet*, May 17, 1890, there is an interesting paper by Poupinel de Valence, Physician to the St. Lazare Leper Hospital, at Port Louis, Mauritius, in which he discusses the question: Is leprosy contagious, or rather, is it transmissible?

Dr. de Valence has passed more than twenty years in an asylum set apart specially for this disease, the St. Lazare Leper Asylum of Mauritius. In a report on the *Spedalsked* which he wrote on May 15, 1882, and which was asked for by the Government of this island, he gave a short account of the first appearance of the disease in the world, and in Europe in the seventh and eighth centuries, as well as a history of its spread in the twelfth to the fourteenth centuries. Its first appearance in Mauritius, it was stated, dates from September 4, 1781, when field laborers were introduced into the island from abroad. Since that report was written this opinion has been modified. At one time no other mode of introduction would be admitted

than that it came into the island through the medium of Kaffirs and Malagassees, who were imported to supply the wants of agriculturists. Dr. de Valence has gathered observations which prove that even at this period there were twenty whites ill of the disease, and that subsequently Europeans who had settled down here and married into perfectly healthy Creole families became ill themselves and transmitted the disease to their wives by cohabitation and to their children by inheritance. He himself, in fact, has had the opportunity of noting the transmission of this affection, and of seeing perfectly healthy servants contract the disease in consequence of having eaten the leavings of their master who was ill.

Transmission by inheritance is, in his opinion, the most powerful means of transmission; and although inheritance is often very difficult to trace it may be done with time. Dr. de Valence says it took him fifteen years before he was able to obtain the proof in certain instances. In order to elucidate this point it is unnecessary to state that much patience during many long years of practice as a medical man is required to gain the confidence of patients and enable the inquirer in the end to bring to light the secret which is usually kept only too well, and which, on exceptional occasions, is unveiled in a moment of unwonted confidence. The following is an example. In the year 1800 there lived in Mauritius a family consisting of four girls of noted beauty. Two married and left the country. The other two were married in the colony. These girls had children affected with leprosy. One can at the present day easily trace the descendants of these four girls and enumerate the members of the family who died from the disease. But it appears that these girls were not the only children in the family. There were also two brothers; one died leprosy, but of the other, in spite of all his researches, Dr. de Valence was unable to find any trace. Hardly eight months ago he at length found a son of his, but in a moribund condition, and he died two days after being discovered. He was a hideous spectacle. He said the man of whom Dr. de Valence spoke above was his father, who died of leprosy without any one knowing the fact. Thus a complete history of inheritance was traced.

Is the disease transmissible by cohabitation? Dr. de Valence does not hesitate to answer in the affirmative. One cannot reason-

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ably deny the fact; and if it cannot more often be proved, it is because the transmission is sedulously concealed by the parties interested, who only acknowledge the fact when they cannot do otherwise. In his pamphlet on the *Spedalsked* he gave a case of a leprous husband who transmitted the disease to his wife. He can affirm to this particular case the more confidently because both persons were under his care and treatment until they died. He now gives at length another case not quite similar in details.

Mr. C—— left Mauritius in search of work in Australia. Finding nothing to do in Melbourne, he shipped as a sailor and went to India, where he made the acquaintance of an Indian girl. He was not long in getting intimate, and one day, having noticed that she had spots on her skin which she appeared to hide, his curiosity was raised, and on watching her attentively, he thought they were of venereal origin, and in consequence visited her more rarely. But, finding that the woman now sought him out, he became uneasy, and left India for Madagascar in order to get rid of her. One morning, having noticed that he had marks on his body and that his face was puffed, he became alarmed, and sailed for the Cape of Good Hope. "I was uneasy," he said, "about my state. Something strange was happening in me without my being able to explain what it was." Some months, however, after his arrival his health seemed to ameliorate, and his face was no longer puffed. His skin was again as smooth as before. "It was then," he said, "I thought of getting married." He married a woman of the Cape, and returned to Mauritius. During the year following his return to this colony the disease declared itself, and some time after he had a little girl, who is now five years of age and leprous. His wife is not affected. He is convinced that it was the woman he had abandoned in India who had communicated the disease to him. Some days before he left for Madagascar he had occasion to see her, and, judging by the intimate knowledge that he has now acquired of the disease, he is certain that it was leprosy she had. The poor fellow who related this story was an intelligent man, whose version of what happened never varied, and it may be accepted with confidence.

Dr. de Valence says of contagion properly so-called—that is to say, transmission by contact: "It would be impossible unless

contagion be admitted, to understand how a person affected with tubercular leprosy, without sores or ulcers, or other solution of continuity, can communicate the disease to a healthy person; and there is proof that he can—inheritance and cohabitation being, of course, put out of the calculation. But medical men attached to leper asylums have on numberless occasions the opportunity of noticing that the air in the wards is contaminated by the pulmonary exhalations as well as by the secretions of the patients. Hence certain volatile organic matters unknown to science—in which the contagion may be present—may be diffused into the air.

"Let us now consider the room in which a leper lives, sleeps, eats, side by side with a healthy person, using the same bed and the same clothes. One cannot but admit the possibility of transmission of the virus in such a case, if there exists only one single example in proof, and such an example is given further on. In spite of the existence of the bacterium discovered by Hansen, the presence of which in the glands was afterwards confirmed by Cornil and Suchard, which discovery has added a step to the proof of the contagiousness of leprosy, all experiments to communicate it to animals by inoculating the cultivated bacteria have had negative results. It may indeed be that the experimenters have been too hasty in proclaiming this result, considering the long incubation of leprosy, and they should have waited five or six years before coming to a decision. I am not aware whether sucking pigs have ever been inoculated. It seems to me that these animals would offer a peculiarly favorable 'culture.' M. Leloir, in a recent article on leprosy, says it is a parasitic disease, proving by this fact that it is contagious. Others deny its contagiousness, and will continue to deny it until positive evidence can be obtained by inoculation. Although I do not know in what way contagion takes place, my conviction is that leprosy is essentially an hereditary disease, that it can be transmitted by cohabitation, and that in certain cases a healthy person may contract the disease by living with a leper. I have shown to my brother practitioners in the island an Indian who contracted the disease from his master, whom he had attended, and with whom he had lived on terms of intimacy for many years. Dr. Para, now in Paris, can if necessary certify to the facts.

"Another case is that of an European lady of healthy parentage, who, being without means, became housekeeper to a family in which some of the members were affected with tubercular leprosy. She lived many years with this family. One by one all the members died of the disease. Five years afterwards she showed signs of being affected, and she, too, died of leprosy at the age of sixty or more.

"To conclude, I may say that it seems to me that the observations quoted in the course of this paper make it difficult to deny that this disease can be transmitted in all the three ways mentioned."

### Oxygen Gas in Pneumonia.

In an article on the value of oxygen gas in pneumonia in the *Lancet*, May 24, 1890, Dr. John Chambers says that during the early months of last year, as a practicing physician in the United States, he met with many cases of the disease, occurring chiefly in adults and men of middle age. These symptoms in the cases observed were due directly to the deficient aeration of the blood. They were marked by difficulty of breathing, together with weakness of the heart's action. The faulty aeration is recognized almost at its onset by the livid hue of the lips, of the ears and the finger nails. This condition is well known to every physician, and, as it is the token of immediate danger to the patient, it is important that the best measures be taken to overcome, if possible, the difficulty. In pneumonic cases in young and old, presenting symptoms of deficient blood aeration, the inhalation of oxygen gas has, in Dr. Chambers's hands, proved to be a remedy of remarkable power. Under its use the lips recover their redness, the breathing becomes easy, and the toneless heart is strengthened in its action.

As to the method of using the gas, a few words may be added. A supply of pure oxygen gas can be easily obtained from the laboratory of a chemist. It is collected in a receiver, and can be conveyed a considerable distance without loss of gas. In the immediate use it is better to fill a rubber bag from the tank than to give the gas directly to the patient. The rubber bag should have a capacity of one or two gallons, and be provided with a stopcock at one end. To this a short rubber tube ending in a mouth-piece can be readily attached. The

mouth-piece is applied over the mouth of the patient, the valve of the bag is turned, and the whole or any portion of the gas in the bag can be inhaled at a single dose. As the gas is heavier than air, its escape from the bag will be facilitated by holding this above the level of the mouth, and slight pressure upon the bag will still further assist in the inhalation. From half a gallon to a gallon of gas can be given every half hour with perfect safety, and with great relief to the sufferer's symptoms. Such doses have been continued for four days and nights, with the most satisfactory results. Life has certainly been saved in many cases when it has seemed that death was inevitable. When cardiac weakness is urgent, an excellent and safe tonic is found in sulphate of strychnia, which may be given in doses of one-eightieth of a grain every four or six hours, until a decided change in the condition of the pulse is manifest. When this occurs the strychnia is omitted, but may be of use again in a day or two if the pulse should fail. The relief in desperate cases, where asphyxia is threatened, is so marked that it is astonishing physicians have not more generally used this simple remedy. The use of oxygen gas imposes a great deal of labor on physicians and nurses. With a little training, however, the nurse soon learns to give the oxygen, thereby relieving the physician. Two nurses should be employed—one for the day and one for the night.

### Poisoning by Antifebrin.

Dr. J. Vierhuff, of Subbath, in Courland, communicates to the *St. Petersburger Medicinische Wochenschrift* the notes of a case of antifebrin poisoning, which are quoted in the *Lancet*, May 24, 1890, and which show what dangers people run who dose themselves with drugs of this class. A healthy young married woman, who had been in the habit of taking antifebrin for headache, feeling the pain come on early one morning last summer took, fasting, about a teaspoonful of the drug in some water. In about ten minutes, the headache not being relieved, she repeated the dose, which her husband remarked might prove dangerous. She consequently took a glass of milk and some alum water in order to produce vomiting, which she succeeded in doing, but immediately afterwards giddiness, singing in the ears, throbbing in the temples and a

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dull pain in the head, together with a feeling of weakness, came on, and the face assumed a livid hue. When seen four hours after the drug had been taken the face was a livid color, the lips blue, the pupils contracted, but the heart, temperature and mental condition were normal. An aperient and a stimulant were ordered. Shortly afterwards the patient became suddenly collapsed, the pulse could not be counted and the breathing was very shallow; in fact, the woman appeared to be dying. The soles of the feet were brushed, vinegar was rubbed on the face and cold water sprinkled over the face and chest; also a mixture of camphorated oil and ether was ordered for injecting subcutaneously. While this was being procured several syringefuls of dilute spirit, which was all that could be obtained, were injected and the patient was brought round, though for three hours and a half her condition appeared hopeless. Then, after recovering somewhat, collapse again came on, and recourse was had to an intravenous injection of a solution of common salt, which appeared to act most beneficially. In about fourteen hours after the drug had been taken the patient was out of danger. After that she continued to improve, though she complained of debility and pain in the limbs for a week. Dr. Vierhuff remarks that the serious symptoms were probably due largely to the patient's taking the anti-febrin on an empty stomach.

### The Germicidal Properties of Urine.

Dr. Lehman, of Würzburg, remarking that urine rarely contains pathogenic bacilli, although they usually abound in the kidneys in infective diseases, determined to inquire whether the absence of bacteria in the urine is due to the filtering process to which it is subjected in the kidneys, or to some inherent germicidal property. The nature of the constituents of urine—viz., acid phosphates, carbonates and aromatic bodies—would seem to render the theory of bactericidal action not improbable. His experiments were conducted in the following way and are quoted in the *Lancet*, May 24, 1890. Fifty cubic centimeters of fresh urine were added to one cubic centimeter of a twenty-four hours old broth culture of anthrax, cholera and typhoid bacilli, and, after being well shaken up, one cubic centimeter of the mixture was employed to fertilize an

agar plate culture. This was kept in an incubation apparatus. In all cases the number of colonies was found to have diminished, the greatest diminution occurring when the initial number of colonies was comparatively small. The germicidal property of the urine appears to be interfered with, if not destroyed, by neutralization with potash and also by sterilization. From some observations made by Dr. Richter it would seem that fresh albumin has a powerful action on the bacilli of anthrax and typhoid, but that the yolk of egg, on the other hand, forms a particularly suitable culture medium for them.

### On Milk Diet in Scurvy.

In the *Bolnitchnaia Gazeta Botkina*, Nos. 5, 6, 7, 8, 9 and 10, 1890, Dr. Mikhail M. Tcheltzoff, of Rybinsk, publishes a suggestive and instructive paper on the treatment of scurvy by a strict milk diet, which was most successfully resorted to by him in twenty-eight consecutive cases of this disease. Five glassfuls of milk were given on the first day of treatment, a glassful being added daily on each subsequent day. No other food whatever was allowed, and no other means, beyond gargling with a two per cent. solution of boracic acid, were employed. The main results derived from Dr. Tcheltzoff's clinical researches may be given as follows: First, a strict milk diet cuts short scurvy in any stage of its course. Second, no relapses occur in cases treated by this method. Third, recovery takes place by far more rapidly than under any other method of treatment. As a matter of fact, of the author's twenty-eight cases, nineteen recovered in about eight days, five in a fortnight and four in three weeks. Fourth, when any other food substances are added to milk, recovery is quite distinctly retarded. Fifth, of all symptoms of the affection, aching pains of the body and the mental depression disappear most rapidly. Sixth, in febrile cases the temperature returns to normal in two or three days, but sometimes even on the first; in some rare cases, however, the fever may subside not before the fifth day. Sixth, later on, all other symptoms gradually disappear, such as subcutaneous swellings or indurations, muscular tenderness, swelling and rigidity of joints, tumefaction and ulceration of the gum, gingival bleeding, etc. Seventh, the



beneficial effects of milk in scurvy must be attributed partly to its being "an ideal food substance," but chiefly to its acting as a medicament endowed with the power of restricting an increased systemic metabolism, and to its increasing the amount of potassium in the system, while decreasing that of chlorides. Eighth, the patients bear the exclusively milk diet quite well (no gastro-intestinal disturbances, etc.). Dr. Tcheltzoff adds that Dr. V. N. Savitch, of Rybinsk, has similarly obtained excellent results from the milk treatment in two severe cases of scurvy, and that milk is regarded by the North-Russian peasantry as an almost specific remedy for the disease.

### Wounds of the Femoral Vein.

At the meeting of the Philadelphia County Medical Society, held May 14, 1890, Dr. Ross P. Cox read the report of a case of wound of the common femoral vein, and, in conclusion, set forth the following facts regarding the treatment and results of wounds of the common femoral vein as taught by cases collected from all possible sources, and tabulated by him.

Of wounds of the common femoral vein, not occasioned by tumor operations, and treated by immediate ligation of vein, there were 3 cases, including the case reported, 2 deaths from gangrene and 1 recovery (the present case).

Of ligation of the common femoral vein for wounds, not done in tumor operations, after trying and failing with compression, there were two cases, 1 death from septicemia and 1 recovery.

In twenty-six cases of ligation of the common femoral vein, wounded in extirpation of tumor, 16 patients recovered and 10 died. Of the 10 deaths, 3 were from hemorrhage, 2 from recurrence of malignant growth, 2 from pulmonary oedema, 1 from pyemia, 1 from exhaustion and 1 from limited gangrene and exhaustion, and a man forty-nine years old was infected generally by sarcoma.

Twenty-seven cases of ligation of the common femoral artery or the external iliac artery and the homologous vein, for wounds made in tumor operations, give 6 recoveries and 21 deaths. Of the 21 deaths, 12 were from gangrene, 4 from septicemia and one each from hemorrhage, recurrence of growth, pyemia and pneumonia. The cause of death of one case was not given.

In wounds of the common femoral vein, not made in tumor operations, treated by ligation of the homologous artery only, out of 5 cases there were 5 deaths, one each from septicemia, gangrene, shock and exhaustion, and in one instance no cause was given.

Of wounds of the common femoral vein, not made in tumor operations, treated by ligation of both artery and vein, there were 17 cases, giving 6 recoveries and 11 deaths. Of the 11 deaths, 5 were from gangrene, 4 had no cause assigned and 2 were from hemorrhage.

Of wounds of the common femoral vein treated by lateral ligation, there were 3 cases, with 1 death from hemorrhage and 2 recoveries.

Of wounds of common femoral vein, not treated by ligation of either vein or artery, there were 11 cases and 11 deaths; 4 from causes not given, 3 from hemorrhage and 1 each from pyemia and gangrene.

### Congenital Double Anophthalmia.

In the Moscow bi-weekly *Meditzinskii Obozrenië*, No. 5, 1890, Dr. V. P. Nebolboff, of Berejnyë Tchelny, details an exceedingly rare case of congenital total absence of the eyeballs, in an otherwise normally-developed, well-nourished and generally healthy peasant boy, two years old, who was brought to the author on account of scabies. On inspection, the upper eyelids were found to be somewhat depressed and hanging down in a valve-like fashion, the patient being able to raise the curtains but to a very slight extent. On separating the lids, a totally empty cavity, or sac, presented itself, its walls being lined with a smooth and continuous mucous membrane. The largest antero-posterior diameter measured 1 centimeter. Corresponding to its posterior end or the apex of the orbit there was seen a circular orifice about 2 millim. in diameter (scarcely admitting a middle-sized probe), leading into a canal similarly lined with a mucous membrane. It proved impossible to determine the length of the cavity. When crying, the boy shed tears quite profusely. His hearing power, as well as smelling, taste and sensibility were quite normal. A couple of years after his coming under Dr. Nebolboff's observation, the patient died from post-scarlatinal dropsy.

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Make communications as short as possible.

NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.

When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

## ETIOLOGY OF CHOLERA INFANTUM.

Passing by such predisposing causes as age, constitutional feebleness, bad hygienic surroundings, impure air and water, dentition, etc., there remain two causative factors in the production of cholera infantum which deserve careful study, namely, high temperature and the food supply.

It is a matter of common observation that the mortality from diarrhoeal diseases in children is greatest during the summer months. The studies of the effect of heat upon these affections, which have been made by Seibert for New York, by Bajinsky for Berlin, and by Meinert for Dresden, are in striking agreement. Seibert (quoted by L. Emmet Holt, in his admirable article on "The Diarrhoeal Diseases of Children," in Keating's *Encyclopaedia*), has shown that, taking the average of a large number

of years, the mortality from diarrhoea increases rapidly from May to July, and then steadily decreases. Thus, from 1877 to 1887, in a total of thirty-one thousand and forty-eight cases, the average mortality during May was six hundred and sixty, during June, four thousand one hundred and three, while during July it reached the enormous number of twelve thousand four hundred and sixty-eight. The mean daily temperature for these same months was respectively 54°, 61° and about 65° Fahr. It would appear from these figures that after the atmosphere, and from it the ground and the dwelling-houses, had become heated to a certain point, say from 55° to 58° Fahr., the addition of a very few degrees produced an enormous increase in the mortality.

It is admitted that heat exerts an unfavorable influence, but just how does it act? Some have supposed that it is by heat stroke or heat exhaustion. Long-continued high temperature is exhausting to adults as well as to children. Its debilitating effects, however, are not due to the heat alone, but to derangements in digestion also. Increased heat means increased perspiration, increased thirst and increased and often indiscriminate drinking. In children the results are more marked because their digestion is feeble, they are more apt to be over-fed and given milk instead of water when they are thirsty (and milk is very prone to decomposition), and because they have less chance of a change in air and hygienic surroundings. The smaller number of deaths during June, notwithstanding the slight difference in temperature, is best explained by the fact that by June the heat has not continued long enough to make the houses hot continuously throughout the twenty-four hours, and the spring months have left the children, in most instances, with considerable resisting power. The fall in mortality which occurs in August and September is due in part to the fact that the deaths which have occurred by that time have diminished the number of children liable to be affected,

and to the fact that we have, as a rule, cooler nights and early mornings, though the temperature at midday may be higher than during July.

When we turn to the food supply, one circumstance stands out prominently before all the rest—it is that breast-fed infants are almost exempt. According to statistics collected by Holt, of nineteen hundred and forty-three fatal cases, only 61, or about three per cent., had the breast exclusively. This fact is conclusive evidence that high temperature in itself is not the most important of the two causes under discussion, and indicate that the heat is harmful chiefly by bringing about certain changes in the food supply of hand-fed children. It is well known that all organic matters are prone to decomposition and putrefaction in summer time, and that cow's milk, which forms the most frequent substitute for mother's milk, is especially liable to these changes, the cause of which is bacteria. Milk is subject to so many sources of contamination from the time it is obtained from the cow to the time it reaches the child, that the marvel is that it is not more frequently the cause of illness. Sterilization of the milk has accomplished much in preventing and in overcoming attacks of cholera infantum, but it has not accomplished all its warmest advocates would have us believe. For there are at all times in the intestines certain bacteria, particularly the bacterium *lactis aërogenes*, or aceticum and the bacterium *coli*. Under a slight catarrh of the bowel or a dyspeptic diarrhoea, which usually precedes an outbreak of cholera infantum, these bacteria multiply in numbers, and a large number of new forms appear. These have been described and cultures of them demonstrated by Baginsky (*Transactions of the Berlin Medical Society*, 1889, p. 139). When these have developed before the milk has been sterilized, it is manifest that subsequent sterilization of the milk will not cure the disease which they have produced. Some of them are undoubtedly capable of

producing disease, as experiments have proved; but no one of them has been found invariably associated with the disease. Two groups of bacteria are seen in the intestinal wall in cholera infantum; in some places bacilli occupy the glands of Lieberkühn and the interstitial tissue, and in other places the glands are filled with heaps of cocci. This being the case, cholera infantum probably is not due to the action of a particular bacterium; in other words, is not a specific disease. Holt believes that the symptoms are produced by toxic alkaloids, ptomaines, developed by the action of the bacteria on the food. Baginsky has gone further. Having discovered that the bacillus which liquefies gelatin and colors it green, develops ammonia by its action on meat, he investigated the stools of cholera infantum for ammonia and found it in considerable quantities. But the abnormal bacteria found in cholera infantum are saprophytes, that is, produce putrid decomposition, and when Baginsky spread meat with the stools of cholera infantum ammonium was produced in greater degree, as was to be expected from the combined results of different bacteria having a common action. Undoubtedly ammonium in the intestines would be a violent irritant, if in sufficient quantity; but we do not see that its absorption would produce a toxic effect. The experiment, therefore, of killing a frog by injecting carbonate of ammonium proves nothing, especially when we recollect how much of this salt can be taken internally by children without harm. Nevertheless, Baginsky's observations are important as showing that cholera infantum is not a specific disease but depends upon the local and systemic action of decomposition products developed by the action of bacteria upon the food. Children are more susceptible than adults for the reasons mentioned in an earlier part of this editorial, and because in them there is a relative deficiency in the secretion of hydrochloric acid, and the bile contains

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less bile salts. Holt appears to adopt the view that bile is not an intestinal antiseptic, but the later investigations of Kossel, referred to by Baginsky, indicate that it is.

It is impossible to overestimate the importance of a correct etiology of cholera infantum. Upon it depends the saving of thousands of lives, through intelligent efforts in preventing the disease and well-directed methods of treatment. Until recent years too little attention has been given to the food supply as the most important cause. The food may cause it by being spoiled, as is the case with adulterated and sour milk; by being improper in kind, such as solid food for nursing children; and also by being given in too large quantities. These three errors in diet usually co-exist. The most important things in prevention are to obtain pure milk and to sterilize it before use, to restrict the diet and to guard against over-feeding. It is better, in summer time, to give children too little rather than too much.

#### THE VAGUS TREATMENT OF CHOLERA.

In these days when so much importance is attached to the operation of bacteria it is rather startling to come across a scientific paper which shows but little respect for these creatures. More than ordinary attention will therefore be attracted to an article on the Vagus Treatment of Cholera, by Dr. Alexander Harkin, in the *Dublin Journal of Medical Science*, March, 1890. Of all the epidemic diseases there is none whose bacterial causation is believed to be more clearly established than that of cholera, yet Dr. Harkin ignores such an etiological relation altogether, and shows that simple vesication over the course of the pneumogastric from the mastoid process to the angle of the jaw is followed by the most surprising results even in the worst form of this disease. In the cholera epidemic on the island of Malta during the year 1877, this treatment was thoroughly tested. Dr. Inglott, one of the

physicians to the Zeitun Hospital, states that "Dr. Harkin's vagus treatment acted in our hands in many cases like magic. I remember well to have seen a boy, eight years of age, at the hospital in so advanced a state of algidism that very little hope there was of saving his life. All internal remedies failed. I was astonished on seeing him dying in the morning, and quite convalescent in the afternoon, after a strong vesication over the vagus. I have no hesitation in stating that Dr. Harkin's treatment is a remedy both reliable and speedy in its action in all severe cases of cholera." Dr. Cannataci, another physician to the same hospital, says that "the vagus treatment failed completely in several cases, but in many cases acted like magic." He relates five cases, and from these and about thirty others of the same kind he concludes that Dr. Harkin's vagus treatment is very beneficial in Asiatic cholera.

It is interesting to learn that this treatment is based on the opinion of Dr. Henry MacCormac, who, as long ago as 1834, taught that cholera is a neurosis, a disease of the sympathetic nervous system, the vomiting, purging, aphonia, vertigo, spasms, cramps, tremors, etc., all revealing their nervous origin. Dr. Harkin believes that by stimulating the vagi he arouses their inhibitory power, which controls and antagonizes the disordered innervation of the abdominal sympathetic. He says its "effect is instantaneous; the purging, the vomiting, and cramps cease; the patient generally falls asleep, and awakes cured, long before vesication takes full effect."

When we consider that cholera has generally been regarded as a hopeless disease, and that protection against it was only to be sought for in prophylaxis, these reports possess more than ordinary interest. The practical testimony which is given in support of the measure seems to be too substantial to be disputed, and the fact that it is based on well-known anatomical and physiological properties of the morbid process is in itself, to say the least, very much in its favor.

### CARELESS ASSERTIONS IN SCIENTIFIC DISCUSSIONS.

There is, perhaps, nothing which does so much to retard progress in science as the habit of making careless assertions—that is, assertions which cannot be established, and which it is sometimes exceedingly difficult to correct, because they get a start of the truth which comes after them, and which needs time to undo the impression produced by its counterfeit which has gone before.

A case of this kind has recently occurred in the *Annual of the Universal Medical Sciences*, for 1889, in which Dr. Harold Ernst, of Harvard, states that Dr. Victor C. Vaughan, of the University of Michigan, had made the suggestion that bacteria may be the products of alkaloids. On having his attention called to this remarkable assertion, Dr. Vaughan asked, in the columns of one of our contemporaries, that Dr. Ernst would point out in the book by Dr. Vaughan and Mr. Novy, which he had said contained this suggestion, the passage where the suggestion was made. In reply, Dr. Ernst refers to a page containing the expression: "We are justified in saying that the micro-organism may be an accompaniment or a consequence of the disease."

The intelligent readers of the *REPORTER* will, no doubt, wonder at the carelessness or recklessness which could have led Dr. Ernst to accuse an eminent investigator who had said a micro-organism might be an "*accompaniment or consequence of a disease*"—a fair and reasonable supposition—of making so silly and unreasonable an assertion as that a micro-organism might be the "*product of an alkaloid*." The worst of the matter is this, however, that, having committed such a blunder in the first place, Dr. Ernst, in the second place, after his attention was specially called to the case, should fail to see that what he cites as authority for a rather contemptuous charge furnishes no support for it whatever; that the editor of a well-known medical journal should fail to see this point; and that doubt-

less many of its readers were taken in too. We happen to know that this has actually occurred, and for this reason, more than any other, we take the trouble to point out the specious or careless character of Dr. Ernst's charge and pretended proof.

Furthermore, the occasion enables us to speak again of the importance of conscientious accuracy in discussing scientific questions and the great damage which is done by carelessness in such matters. In the case referred to, one of two things must happen: either it will be supposed that Dr. Vaughan committed the folly charged to him by Dr. Ernst, or it will be known that Dr. Ernst carelessly brought a false charge against him. One scientific reputation is sure to suffer in either case; and, unfortunately, it is by no means certain that that one will suffer which deserves it.

### BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

**FOURTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH OF THE STATE OF OHIO.** 8vo, pp. 350. Columbus, Ohio: The Westbote Co., 1889.

This Report is for the year ending October 31, 1889. It is a very complete presentation of matters pertaining to the public health in Ohio. The State Board has been able to accomplish this by constant communication with local Boards throughout the State. Every city, and every village having over five hundred inhabitants, with the exception of forty-two, has now such a local Board. In order to learn the amount and character of the sanitary work done through the local Boards, the State Board issued a circular-letter, containing a series of questions. In many cases these were answered by the local health officers, and they give a very good idea of the needs of the respective communities and of the work done by the health officers.

The volume concludes with several papers on sanitary subjects, such as the care of the eyes, water supply, systems of sewerage, etc. Altogether the publication is a very creditable one.

**TRANSACTIONS OF THE AMERICAN OTOLOGICAL SOCIETY.** Twenty-second Annual Meeting, New London, Conn., July 16, 1889. Vol. iv, part 3, 800, pp. 513. Published by the Society, 1889.

The first paper in the present volume is one by Dr. B. Alexander Randall, of Philadelphia, on the Perforation in Shrapnell's Membrane. This perforation has been found frequently since the author began to search for it carefully. Notes of twenty cases are

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given briefly. The author emphatically denies that such a thing as a normal foramen of Rivinus exists, and asserts that all such perforations are pathological. The paper gave rise to an interesting discussion.

The second paper is by Dr. F. M. Wilson, Bridgeport, Conn., on Three Deaths following Suppurative Otitis, with two Autopsies. One of the deaths was from purulent meningitis, the other from abscess of the cerebellum.

Following these papers are several shorter ones, and the volume concludes with an extremely valuable alphabetical index of otological literature, from July, 1888, to July, 1889, compiled by Dr. Gorham Bacon, of New York City.

Judging by the Transactions, the Otological is an ideal scientific society. The papers presented are of a strictly scientific character, there are few of them, and the discussions upon them are full and valuable. The volume before us is handsomely printed on excellent paper.

TRANSACTIONS OF THE TWENTY-FIFTH SESSION OF THE HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA. Held at Pittsburgh, September 17-19, 1889. 8vo, pp. 320. Philadelphia: Sherman & Co., 1890.

The present volume contains the usual number of papers. Most of them consist in the reports of cases, with details of the symptomatic treatment adopted. The late President of the Society, Dr. Wm. B. Trites, contributes an interesting paper on Herpes Zoster. In one case a persistent supraorbital neuralgia followed an attack of herpes frontalis. Dr. Van Lennep's paper, on Experimental Studies in Intestinal Surgery, etc., differs from the large majority of the others in having some claim to be considered scientific. The author recommends the use of soft rubber drainage-tube, made into rings, as a substitute for bone plates, catgut rings or mats, or rubber discs, in the operation of lateral anastomosis. He regards end-to-end union, after resection, as the ideal operation.

DIE MICROORGANISMEN DER MUND-HOEHL. VON W. D. MILLER, Dr. Med. et Phil., etc.

THE MICRO-ORGANISMS OF THE ORAL CAVITY. BY W. D. MILLER, M. D., Ph. D., Professor at the Dental Institute of the University of Berlin. With 112 illustrations and one colored plate. 8vo, pp. 305. Leipzig: Georg Thieme, 1889.

Dr. Miller's excellent work on the micro-organisms of the oral cavity is one of the most interesting books of this class that it has been our fortune to review. The opening chapters are devoted to bacteriology in general, and give the reader a clear and concise knowledge of the subject. In these Dr. Miller has been largely guided by Flügge's classical work. Caries of the teeth, and its prophylaxis, are very thoroughly discussed, and the second part of the book is devoted entirely to the consideration of diseases produced by pathogenic micro-organisms found in the oral cavity. The book is very fully illustrated with beautiful engravings, and would be a valuable addition to the library of any student of bacteriology.

WEEKLY ABSTRACT OF SANITARY REPORTS, issued by the Supervising Surgeon-General, M. H. S. Vol. iv. Nos. 1 to 52. 8vo, pp. 490. Washington, D. C., 1890.

The volume of the *Weekly Abstract of Sanitary*

*Reports*, for 1889, will prove a valuable addition to our editorial library. The Weekly Abstracts, singly, can easily go astray, and both for the sake of preservation, as well as convenience, their reappearance, in a bound volume, is most welcome.

## CORRESPONDENCE.

### Correction.

TO THE EDITOR.

*Sir*: In my paper on "The Differential Diagnosis and Treatment of the Continued Fevers of the Southern States," June 7, the reader will note the following corrections.

On page 659, second column, line 15 from bottom, instead of "typical" read "atypical."

On page 660, first column, line 3 from top, instead of "like" read "unlike." And in the line following, instead of "typical" read "typhoid."

On same page, second column, line 14 from top, instead of "typical" read "atypical."

Same page, second column, line 30 from top, instead of "intermittent" read "remittent."

On page 662, second column, first line at top, instead of "first" read "further."

B. F. HUMPHREYS.

Hawkins, Texas.

## NOTES AND COMMENTS.

### Simple Treatment for Epistaxis.

Dr. A. H. Fridenberg, in the *New York Medical Record*, April 19, 1890, says: Not very long ago a man walked into my office bleeding profusely from the right nasal cavity. He had similar attacks on previous occasions, which were always very difficult to manage, and during one of them he had nearly bled to death, despite the efforts of the two physicians in attendance. He had finally to be transported to the hospital, where the hemorrhage was checked with the assistance of Bellocq's canula. The present attack had lasted three or four hours, and the patient declared he had lost a pint of blood. During the ten minutes or so that he had been awaiting his turn in the waiting-room, he had filled the bottom of a cuspadore to the depth of two inches with blood coagula.



Despite his powerful physique—he was tall, and weighed about two hundred and fifty pounds—he showed signs of great weakness, was pale and exsanguinated, and breathed with difficulty through the mouth, the nose, from which blood rapidly dripped, being stopped up with clots. I seated him and packed his nasal cavity with absorbent-cotton pledgets, squeezed dry of carbolized solution, but without avail. The blood oozed through the firm packing. I removed the cotton, made him blow out the blood-clots, and introduced Goodwillie's nasal speculum, but failed to recognize the source of the hemorrhage, owing to the impossibility of wiping away the blood as rapidly as it welled up from the deeper recesses. What I did recognize, however, was the fact that the man was rapidly growing weaker, and that he was in imminent danger of falling from the chair in a swoon. There was but one thing to do, and that was to cork up his nasal passages, anteriorly and posteriorly, without loss of time. I had no Bellocq's canula, however, and there was no time to procure one. In this predicament I be-thought me of a simple substitute for the Bellocq, which served me so well that the hope that it may render the same service to others, under the same embarrassing circumstances, must be my excuse for presenting this account of an otherwise very uninteresting experience. I had some rubber drainage-tubing, of assorted sizes, on hand, from which I selected a piece of small caliber, but of sufficient resiliency, about the thickness of a parlor match, and about ten inches in length. One end of this I introduced into the right nasal cavity, and pushed it along the floor of the inferior meatus, through the clots, until it reached the pharynx, whence it curled forward within easy reach of forceps, by which it was drawn out at the mouth, meeting the other end projecting from the nose. The subsequent steps were similar to those employed after the passing of the Bellocq canula. To the mouth end of the tubing I attached a small, compact wad of elastic lamb's wool, rolled in iodoform gauze, and, drawing upon the nasal end, I slipped the wad into the post-pharyngeal space and stretched the tubing until the cessation of all trickling of blood down the post-pharyngeal wall showed that the post-nasal aperture was occluded. Still keeping the tubing tightly drawn to its fullest extent, I rapidly packed the anterior nasal recesses with long strips of iodoform gauze to just

within the nostril, all around the tubing. I now tied a knot in the rubber, close to its exit at the nostril, and through it passed a cross-piece of tubing of somewhat larger caliber, just long enough to fit easily inside the nostril. Finally, releasing the end of the rubber, its elasticity caused it to fly back, so that the knot and cross-piece rested upon and firmly held in place the anterior gauze packing. The nasal cavities were thus firmly occluded at both outlets, without any external evidence of the tampon, or any unsightly bulging of the soft parts of the nose. The elastic tubing was at just a sufficient tension to support the packing without the least discomfort to the patient. After forty-eight hours it was easily removed, without recurrence of the hemorrhage, by slightly drawing the knot out of the nostril and cutting the tubing just behind it.

#### Prophylaxis of Cholera.

The *Abstract of Sanitary Reports* of the U. S. M. H. S., June 20, 1890, contains the following from the *Journal d'Hygiène*, May 22, 1890.

Dr. Legrand, sanitary physician at the French hospital at Suez, has recently published a pamphlet entitled *Contribution to the Study of the Modern Sanitary Prophylaxis of Cholera*. His conclusions are:

1. That the mode of propagation of cholera by the dejections of patients, by impure water and unclean clothing, allows of the establishment of a system of rational prophylaxis, based on medical inspection and disinfection.

2. That long quarantines are useless. The observation still necessary at the present stage of science should be limited strictly to the period of incubation, five days in all, taking into account the length of the voyage, provided that during this period thorough sanitation of the ship and of all movable effects be practiced.

3. That the most efficacious and practical means of disinfection are: Steam-pressure stoves; chemical disinfectants, among which may be mentioned solutions of sulphate of copper, chloride of zinc (5 to 2 per cent.), milk of lime, freshly prepared (20 to 7 per cent.), and solutions of sublimate in the proportion of 1 to 1,000. The latter are preferable to all other disinfectants. Although sulphurous acid does not figure in this catalogue, Dr. Legrand states that

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sulphurous acid is efficacious when applied in connection with humidity.

According to Jungfleisch, when sulphurous acid exists in the nascent state in a humid atmosphere it forms an oxyhydro-sulphuric acid which is much more penetrating than sulphurous acid.

Dr. Legrand's work forms an interesting chapter of public and international hygiene. In the course of his scientific exposition of the subject the author refers to the prediction made by Fauvel after the cholera epidemic at Toulon: That at no distant day quarantines properly so-called shall disappear before the irresistible force which tends to multiply international relations, and shall be replaced by preventive measures of a very different order.

### An Epidemic of Pulmonary Phthisis.

Dr. Marfan, chief of the medical clinic of the Faculty of Medicine of Paris, gives, in the *Semaine Médicale*, October 23, 1889, the details of a localized epidemic. In an important business house in the centre of Paris, twenty-two persons were employed about eight hours a day. One of them, aged forty, employed at this place for twenty-four years, had been phthisical for three years, when he died on the 6th of January, 1878. He coughed and spat upon the floor for three years, and did not leave his work till three months before his death. From that time, out of twenty-two persons employed, fifteen have died. One only died of cancer, the remaining fourteen died of pulmonary tuberculosis. One year before the death of the first person, who appears to have been the starting point of the epidemic, two employés, who had been connected with the same business for more than ten years, began to cough and spit upon the floor. They died in 1885. Beginning with the end of 1884, the deaths followed each other at closer intervals.

Dr. Marfan states the unsanitary conditions of the apartment in which these persons were employed. It was small, and the cubic air-space was less than ten cubic metres (350 feet) to each person. It was badly ventilated, badly lighted, and the gas was burned a part of each day, especially in winter. The floor was of wood, uneven, cracked and very dirty. The first victim of phthisis and those who followed spat directly on the ground, and the sputa becom-

ing dry, was converted in this already unhealthy apartment, into a poisonous dust. The room was swept each morning, and sometimes the employés arrived before the sweeping was finished and while the dust was still floating in the air. It was difficult to sweep the room thoroughly, since the tables were fixed to the floor. It appears very probable that the swallowing and inhaling of this tuberculous dust was an essential factor in the propagation of the disease.

The proprietors of the place where the deaths occurred removed and burned the floor, and so rapidly was the work accomplished that the reporter had no time to collect a sample of the dust from the cracks in the floor for the purpose of experiments upon animals. A new floor was laid, which was waxed and treated from time to time with spirits of turpentine, all painted surfaces were repainted, and Dr. Marfan recommended that the floor should be swept in the evening after the departure of the employés, and that the windows should be left open all night.

Dr. Vallin recommends in place of these measures a mixture of equal parts of coal-tar and spirits of turpentine, or of paraffine dissolved in warm petroleum, and in place of the sweeping, the removal of the dust by sponges, or cloths moistened with an antiseptic solution.—*Boston Med. and Surg. Journal*, May 1, 1890.

### Resection of the Stomach.

Before the Medical Society of Hamburg, January 28, 1890, Schede presented a woman, 51 years of age, in whom, for carcinoma, he resected three-fourths of the stomach. Since the previous summer there had been emaciation. In September a movable tumor, about the size of a kidney, was observed in the abdomen, below the umbilicus, without other symptoms. An incision, December 23, disclosed a carcinoma of the stomach, involving almost the entire organ, but one-fourth being free. The extirpation was easy, as the duodenum was supplied with a long mesentary and the glands were not infiltrated. It was thus possible to make the incision through the gastro-colic omentum close to the greater curvature. The patient made a good recovery from the operation and increased rapidly in weight. Microscopic examination disclosed the epithelium from the region of the incision near the tumor, in a

state of active proliferation and nuclear division. To prevent stretching of the cicatrix, Schede unites the peritoneum and the deep fascia with fine, buried silver sutures. Deep silver sutures are also applied and finally superficial, continuous catgut sutures. Union occurs without reaction.—*Deutsche medicin. Wochenschr.*, June 5, 1890.

### Pulsation in the Uvula and Aortic Insufficiency.

In ordinary conditions of health there is no pulsation in the soft palate, or uvula, that is visible on simple inspection, so that when such a pulse is present it may, as a nearly constant rule, be taken as a sign of disease. In a recent memoir in the *Charité Annalen*, Dr. F. Müller, of Berlin, has reported a case in which he observed rhythmical pulsations of the soft palate. The case was one of aortic insufficiency. A slight attack of pharyngitis led to an inspection of the throat, when it was seen that with each carotid pulsation the tonsils and pillars of the fauces moved slightly towards the median line, while the soft palate and uvula were somewhat lowered, so that there was a rhythmical contraction of the faucial opening at the same time that there was an increase in the redness of the mucous membrane. Inspection of the throat after the inflammation had subsided showed the pulsations still present, though somewhat less pronounced. His attention having been thus called to this peculiar condition, Dr. Müller searched for it in six other cases of aortic insufficiency, and found it four times in a total of seven cases.

In an article in the *Gazette Hebdomadaire de Médecine et de Chirurgie*, March 15, 1890, Dr. P. Merklen quotes these cases and refers to an observation of his own. The patient was a young man who had a double mitral and aortic lesion, with marked hypertrophy of the auricle and left ventricle. The sub-lingual capillary pulse was distinct, and in addition the palatal pulse was very evident on inspection. This was more particularly marked in the uvula, which could be seen to swell synchronously with the carotid and radial pulses.

Although, as Dr. Merklen remarks, this sign can have no great clinical value as an aid to diagnosis, it would, nevertheless, be interesting to learn with what constancy it is present in cases of aortic insufficiency,

and whether the pulsation is ever visible in any other conditions. Müller never observed it in any other cases than those of aortic insufficiency, and Merklen has also examined many patients without this condition, but failed to find any pulsation. It is certainly not present in all cases of aortic insufficiency, for Müller looked for it in four such cases, but could not detect it. The palatal movements are not caused by transmission of the carotid beat, but are probably produced in the same way as the capillary pulse seen under the finger-nails in cases with similar cardiac lesions.—*Medical Record*, May 31, 1890.

### Timbo, a Brazilian Fish Poison—Timboin.

At a meeting of the Society of Naturalists and Physicians of Strassburg, February 14, 1890, Dr. Pfaff described a plant found by him at the entrance of the Rio Branco into the Rio Negro, called *Paullinia pinnata* by Martius. Timbo is used by the native Brazilians as a fish poison and as a remedy in diseases of the liver. The active principle is a crystalline, non-nitrogenous body, soluble in water, alkalies and acids, combining with acids in the presence of heat to form crystalline needles. Dr. Sobieranski described the physiological action of timboin. In frogs, .0005 gm. ( $\frac{1}{2000}$  gr.) was found to be a toxic dose. Watery emulsions of timboin were injected into the dorsal lymph sac. On account of its insolubility the effects occurred late. In from 6 to 10 hours, diminution of reflex irritability and of sensibility was noticed, followed by complete paralysis. In rabbits, death took place after the injection of .05 gm. ( $\frac{3}{4}$  gr.) per kilo (2 lbs.) At first, the posterior extremities were dragged. Then there was marked disturbance of equilibrium, with diminution of sensibility. Later on the disorder of co-ordination progressed to rolling movements, analogous to those observed from electrical stimulation of the cerebellum. Death occurred in coma, with infrequent, irregular, costal respiration. Smaller doses caused diminution of sensibility and slight narcosis. These symptoms appeared more decidedly in dogs. Two to three decigrams (3 to 4½ grs.) produced disturbances of equilibrium and a condition of intoxication. The gait was stumbling, as after alcohol or chloral. Sensibility was diminished from the

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first. Later there were rolling movements. Finally the respiratory movements grew fewer in number and death resulted from cessation of respiration. If artificial respiration were employed the blood pressure remained high, and it was possible for recovery to take place. Timboin belongs to the group of nerve poisons which, in small doses, diminish sensibility and produce narcosis, in large doses cause coma and cessation of respiration.—*Deutsche med. Wochenschrift*, June 5, 1890.

### Easton Medical Society.

Notwithstanding the elevated temperature, the active practitioners of this city have formed an Easton Medical Society, to hold monthly meetings in the evening at their rooms. Its object is the reading of papers and the presentation of clinical subjects. A reading-room containing the most prominent medical journals, is an additional attraction. The following are the officers of the Society: President, Dr. Jacob R. Ludlow; Vice-Presidents, Drs. H. D. Lachenour and Isaac Ott; Secretary, Dr. B. Rush Field; Treasurer, Dr. E. W. Evans; Executive Committee, Drs. W. C. Cox, H. D. Michler and Isaac Ott. It is hoped that this Society will serve to promote a more intimate exchange of medical views about the every-day work of the members as well as the inculcation of a more liberal and social spirit.

### NEWS.

—Dr. Samuel Wolfe, formerly of Skipack, Pa., has removed to 828 North Seventh street, Philadelphia.

—The Congress of the French Association for the Advancement of the Sciences will be held at Limoges from August 7 to 14.

—Dr. Schneider, Professor of Zoölogy and Director of the Zoological Museum in the University of Breslau, died on May 30, 1890.

—It is reported that recently a New York baby fell five stories and landed unhurt, except for a little bump on its forehead and a slight sprain of one of its ankles.

—Dr. Brieger, whose name is favorably known for his original work in bacteriology and general pathology, has been appointed Extraordinary Professor in the University of Berlin.

—The three cases of suspected leprosy which were detained at the Boston Quarantine Station, from the brig Canadian, from Surinam, have been found to be free from the disease, and were allowed to land.

—Dr. Lewis Baker, of Lickdale, Pa., whose name does not appear in the Medical Directory, was arrested in Lebanon, June 30, on the charge of malpractice resulting in a woman's death. He was committed to prison in default of \$1,000 bail.

—Medical Inspector Taylor submitted to the Board of Health of Philadelphia, on July 5, a report embodying the results of his examination of the sanitary condition of the public schools in the wards from the first to the eighteenth inclusive. He reported serious sanitary defects in thirty school-houses.

—Cornelius Vanderbilt and his mother are about to build a "People's Palace" in New York. It will be modeled upon the institution bearing that name in London, and will cost \$250,000. It will contain departments for technical and industrial education, mission schools, food and shelter, gymnastics, libraries, etc.

—Dr. William P. Pierce, a graduate of the University of the City of New York in 1852 and now Mayor of Hoopeston, Illinois, was on trial, July 1, in the U. S. Court in Springfield for selling liquor without a license. He was elected Mayor on the Prohibition ticket and closed all the saloons. The allegation is that he and his partner ran a drug store and sold whiskey on the prescription plan.

—Dr. José de la Luz Hernandez, one of the oldest and most esteemed members of the medical profession in Havana, died on May 3, 1890. He took his degree in medicine in 1826, and up to a few years ago took a most active part in public professional life. He was one of the pioneers of hygiene in Cuba, having given public lectures on the subject as far back as 1840, and having been instrumental in introducing many sanitary improvements in the city of Havana.

—The Sanitary Service has recently been reorganized in Brazil, a Central Council having been established at Rio de Janeiro and subordinate authorities in each State. The functions of these bodies are of a most comprehensive character, for they are charged not only with the control of the sanitary administration, but with the regulation of medical practice and the sale of drugs, and with the completion and

improvement of the Brazilian Pharmacopœia.

—The new rule of the Board of Health of Philadelphia, prohibiting burials before undertakers have obtained permits from the Board, went into effect July 1, and caused considerable dissatisfaction among undertakers. The Board, however, on July 2, modified the regulation, so far as it refers to undertakers in the twenty-first, twenty-second and twenty-third wards and Bridesburg. Owing to the distance of these places from the Health Office, undertakers there may bury without obtaining a permit.

—The new Croton aqueduct, which is now nearly ready for use, is 30.75 miles long, all of which is in tunnel, except for a trifle of over one mile. The water comes to the surface in four places, at which it can be emptied through gates into several streams. It starts from the Croton Lake, in Westchester county, 350 feet above the dam, and the water flows down a uniform inclination of 7 1-10 feet to the mile. The tunnel is a trifle over 13½ feet high and over 13 feet wide, and has an estimated capacity of 318,000,000 gallons a day.

—It was reported from Madrid, Spain, under date of July 1, that during the two weeks before that date, there had been 144 cases of cholera and 36 deaths from the disease in Gandia. The medical authorities were of the opinion that the disease would not spread further. The latest cases were of a more benignant type. On July 6 it was reported that the cholera epidemic in Valencia, Spain, had slightly increased. Eleven new cases and three deaths were reported at Rolova, and three new cases and three deaths at Gandia on July 6.

—The highest death-rate ever recorded in Norristown, Pa., was that of June, the number of deaths being 51, or one to every 339 inhabitants, the population, according to the count of the census enumerators, being 17,312. This is an excess of 40 on the deaths for the same month last year. Twelve of the deaths for June were due to dysentery. The Board of Health regulations provide that no person dying of an infectious disease shall be given a public funeral, but thus far the provision has not been enforced in a single instance.

—The House Committee on Invalid Pensions has agreed to report favorably a bill pensioning army nurses. It provides that all women employed by the Surgical Department of the United States as army nurses

or otherwise officially recognized as such during the late war, and who rendered service in hospitals, in camp or on the battlefield for a period of six months or more, and who were honorably discharged, and who, from the results of such services or the infirmities of advancing age, are unable to earn their own livelihood, shall receive a pension of \$12 per month.

—Representative Laws on June 30 introduced a bill in Congress providing for the appointment by the President of a Commission, consisting of five persons, to make an impartial and thorough investigation of social vice in all its phases, in relation to labor and wages, marriage and divorce and the general welfare of the people. When this investigation is completed the Commission shall report its results to the President, who shall transmit the same to Congress. A similar bill was introduced in the Senate by Mr. Frye with the statement that it was presented by request of the Women's Christian Temperance Union of the United States.

—Dr. E. H. Horsey, a graduate of the Royal College of Physicians and Surgeons, Kingston, Ontario, in 1860, and for fifteen years resident physician at the Palmer House in Chicago, died suddenly on Tuesday evening. He had been suffering for some time, and on Monday submitted to an operation. He was left in charge of a man known as S. W. Nicholas, of Covington, Ky., who is said to have not only neglected his duty, but has mysteriously disappeared. When last seen he appeared intoxicated, but sent a despatch to his home saying he was insane. There seems to be a measure of mystery surrounding the case that no one has been able to satisfactorily solve.

—The Health Department of New York, on June 30, appointed the fifty physicians of the "summer corps," and on Wednesday, July 2, they began their work among the poor of the tenements. Of the value of this work, which will continue during July and August, the following figures from last year will convey some idea. There were 264,000 families visited, 16,148 sick people prescribed for, 12,000 tickets for free excursions distributed and 50,000 circulars containing simple instructions for the care of children given away during the hot months. This work was chiefly among those unable, through poverty, to secure the medical treatment and medicine which the Board of Health furnished free.

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